CCME

2018 External Quality Review

ABSOLUTE TOTAL CARE

Submitted: March 27, 2019
Revised April 26, 2019

Prepared on behalf of the
South Carolina Department
of Health and Human Service

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies that contract with Managed Care Organizations (MCOs) to evaluate their compliance with state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358*. This report contains a description of the process and the results of the *2018 External Quality Review (EQR)* conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the South Carolina Department of Health and Human Services (SCDHHS). This review determines the level of performance demonstrated by Absolute Total Care (ATC) since the 2017 Annual Review.

The goals of the review are to:

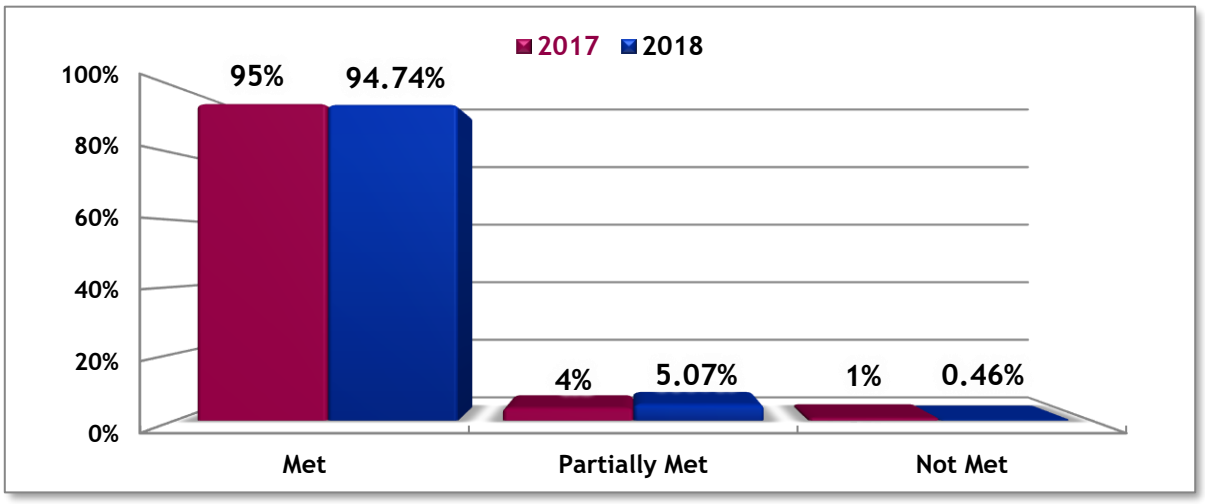
- Determine if ATC is in compliance with service delivery as mandated in the MCO contract with SCDHHS
- Evaluate the status of deficiencies identified during the 2017 Annual Review and any ongoing quality improvements taken to remedy those deficiencies
- Provide feedback for potential areas of further improvement
- Validate contracted health care services are being delivered and of good quality

The process CCME uses for the EQR is based on the protocols developed by the Centers for Medicare & Medicaid Services (CMS) for Medicaid MCO EQRs. The review includes a desk review of documents, a two-day onsite visit, a telephone access study, compliance review, validation of performance improvement projects (PIPs), validation of performance improvement measures, and validation of satisfaction surveys.

Overall Findings

The 2018 Annual EQR reflects that ATC achieved a “Met” score in 94. 74% of the standards reviewed. As the following chart indicates, 5.07% of the standards are scored as “Partially Met,” and less than 1% (0.46%) of the standards score as “Not Met.” The chart that follows provides a comparison of ATC’s current review results to the 2017 review results.

Figure 1: Annual EQR Comparative Results



An overview of the findings for each section follows. Details of the review as well as specific strengths, weaknesses, any applicable quality improvement items and recommendations can be found further in the narrative of this report.

Administration:

Absolute Total Care (ATC) is a subsidiary of Centene Corporation (Centene), headquartered in St. Louis, Missouri. John McClellan is President and Chief Executive Officer (CEO), responsible for ATC's day-to-day business activities and accountable to the Board of Directors and Centene. CCME's review of staffing confirms all contractually required positions are filled; however, the Senior Vice President of Quality Improvement is also serving as the Interim Vice President of Medical Management. ATC reports continued recruiting activities are being conducted to fill the Vice President of Medical Management position, and recruitment and hiring activities are in process for all current staff vacancies.

Appropriate processes are in place for policy review and revision. Staff have appropriate access to policies and are alerted to new policies and policy revisions by departmental leadership and compliance staff.

ATC's Information Systems Capabilities Assessment (ISCA) documentation demonstrates commitment to the fundamentals of data security (confidentiality, integrity, and availability). The focus on data confidentiality is reflected in the company's policies and procedures and the emphasis on data integrity and availability is reflected in its disaster recovery (DR) plan. The DR plan was tested and was successfully completed within the allotted recovery timeframe. ATC and Centene continue to perform actual remote

location disaster recovery testing, while many organizations are performing more abbreviated tabletop recovery exercises.

The *Compliance and Ethics Program Description, Fraud, Waste and Abuse Plan*, and associated policies provide guidance on requirements and processes to ensure staff compliance with conduct standards and to detect and prevent fraud, waste, and abuse. Compliance training is provided at appropriate intervals and staff must complete annual Conflict of Interest disclosures. CCME identified weaknesses related to exclusion status monitoring, and confidentiality training. CCME discussed actions needed to correct these issues with ATC.

Provider Services:

The Credentialing Committee is chaired by Dr. Robert Thompson, Medical Director, and additional voting members include four network providers with specialties in pediatrics, surgery, and psychiatry. Dr. Cheryl Walker-McGill, Medical Director, serves as an alternate and attends meetings rarely. A review of meeting minutes shows the quorum of two thirds of voting members was met at each meeting.

Policies define ATC's comprehensive credentialing program; however, the requirement to query the Suspended List and the Behavioral Health Actions List required by SCDHHS Program Integrity is not addressed. The queries are not present in the credentialing/recredentialing file review. ATC staff confirmed that credentialing and recredentialing of behavioral health (BH) providers is no longer conducted by Envolve PeopleCare (formally Cenpatico) and is now integrated in to the regular credentialing process conducted for the local health plan.

A review of the adopted clinical practice guidelines shows inconsistencies between the website and *Provider Manual*.

CCME conducted a *Telephonic Provider Access Study* focusing on primary care providers. Results show calls were successfully answered 60% of the time (148 out of 246) when omitting calls answered by personal or general voicemail messaging services. When compared to 2017 results of 51%, this year has a marginally significant increase in successful calls.

Member Services:

ATC has policies that define member rights and responsibilities and processes for informing members of their rights and responsibilities. Information is included in the *Member Handbook*, *Provider Manual*, and on ATC's website. The information is occasionally presented in member newsletters, and network providers are required to post member rights in their offices.

Member education about the health plan, benefits, and services is primarily provided through the *Member Handbook*. Members are encouraged to contact Member Services for any questions. Member newsletters provide supplemental information about the health plan, benefits, and additional information about various topics of interest to members.

The *Member Handbook* provides a list of preventive health guidelines and refers members to the website to view the detailed guidelines. ATC encourages members to obtain recommended preventive services, including well-child services, through mailings, telephonic outreach, materials placed in provider offices, and the Member Connections Program. The CentAccount® Rewards Program provides monetary incentives for members to complete healthy behaviors.

Member satisfaction surveys are conducted by a certified Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey vendor. Response rates continue to be below the National Committee for Quality Assurance (NCQA) target rate, and CCME offered suggestions to improve response rates for future surveys. Reporting survey results to appropriate committees and to network providers is evident in the materials CCME reviewed.

Although documentation of contractually-required grievance processes was thorough in policy and in member and provider materials, onsite discussion confirmed ATC has an internal process for handling grievances determined clinically urgent. This process is not sufficiently documented in policy. The review of grievance files resulted in a concern related to lack of provider re-education about plan processes and requirements—particularly related to the requirement that pharmacies must issue members a limited emergency supply of medications that require prior authorization.

Quality Improvement:

For the Quality Improvement (QI) section, CCME reviewed the *2018 Quality Assessment and Performance Improvement Description Medicaid,* committee structure and minutes, performance measures, performance improvement projects, and the QI program evaluation. ATC's *2018 Quality Assessment and Performance Improvement Program Description Medicaid* describes the program's quality improvement structure, function, scope, and goals as defined by the health plan.

ATC has reviewed and adopted several Clinical and Preventive Practice Guidelines. Network providers are informed of the guidelines and the expectation that they follow the guidelines. At least annually, ATC measures provider compliance with the guidelines. The monitoring processed used by ATC is described in *Policy SC.QI.08, Clinical & Preventive Practice Guidelines*. The policy states "ATC measures practitioner compliance with at least two measures for each of the four clinical guidelines." The policy further indicates a total score of 80% compliance must be met or a corrective action plan is

required. Results of monitoring was only found for Diabetes, Asthma, and Well Child Visits. Diabetes and Asthma results show the providers met the 80% compliance rate. The goal set for the Well Child Visits does not follow ATC's policy of 80% compliance. This goal was set at the 75th Quality Compass percentile. The results fell below this goal; however, corrective action was not documented.

Performance measures and performance improvement projects met the CMS validation requirements. Comparison of the Healthcare Effectiveness Data and Information Set (HEDIS) measures from the previous year to the current year revealed a strong increase (>10%) in several rates, including BMI Percentile, Counseling for Nutrition, Counseling for Physical Activity, and Asthma Medication Compliance for 19-50 year-olds. The measure that decreased substantially (>10%) was Persistence of Beta-Blocker Treatment After a Heart Attack. *Table 1: HEDIS Measures with Substantial Change in Rates* highlights the HEDIS measures with substantial increases or decreases in rate from last year to the current year.

Table 1. HEDIS Measures with Substantial Changes in Rates

MEASURE/DATA ELEMENT	HEDIS 2016	HEDIS 2017	Change from 2016 to 2017
Substantial Increase in Rate (>10% improvement)			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	68.75%	79.56%	10.81%
Counseling for Nutrition	56.01%	67.40%	11.39%
Counseling for Physical Activity	44.71%	63.02%	18.31%
BMI Percentile	68.75%	79.56%	10.81%
Medication Management for People With Asthma (mma)			
19-50 Years - Medication Compliance 50%	45.60%	56.52%	10.92%
Substantial Decrease in Rate (>10% decrease)			
Effectiveness of Care: Cardiovascular Conditions			
Persistence of Beta-Blocker Treatment After a Heart Attack	65.38%	51.35%	-14.03%

ATC reported 12 quality clinical withhold measures for 2017. As per the *SCDHHS Medicaid Playbook* and *Managed Care Organizations Policy and Procedure Guide*, individual measures within quality index are weighted differently. A point value is assigned for each measure based on percentile (<10 Percentile = 1 point; 10-24% = 2 points; 25-49% = 3

points; 50-74% = 4 points; 75-90% = 5 points; >90% = 6 points). Points attained for each measure are multiplied by individual measure weights then summed to obtain the quality index score. The 2017 rate, percentile, point value, and index score are shown in *Table 2: Quality Withhold Measures*. The Women's Health measure rates generated the highest index score, followed by Diabetes and Pediatric Preventive Care.

Table 2: Quality Withhold Measures

Measure	2017 Rate	2017 Percentile	Point Value	Index Score
DIABETES				
Hemoglobin A1c (HbA1c) Testing	89.23%	90	6	5.15
HbA1c Control (< =9)	49.45%	25	3	
Eye Exam (Retinal) Performed	52.19%	50	4	
Medical Attention for Nephropathy	93.80%	90	6	
WOMEN'S HEALTH				
Timeliness of Prenatal Care	90.51%	90	6	5.40
Breast Cancer Screen	62.88%	90	6	
Cervical Cancer Screen	66.18%	75	5	
Chlamydia Screen in Women (Total)	58.52%	50	4	
PEDIATRIC PREVENTIVE CARE				
6+ Well-Child Visits in First 15 months of Life	68.37%	75	5	4.1
Well Child Visits in 3rd,4th,5th&6th Years of Life	65.94%	25	3	
Adolescent Well-Care Visits	53.28%	50	4	
Weight Assessment/Adolescents: BMI % Total	79.56%	75	5	

ATC submitted four projects. They included Improving Dilated Retinal Exam Screening, Post-Partum Care, Member Satisfaction, and Provider Satisfaction. The Improving Dilated Retinal Exam Screening and Member Satisfaction PIPs were retired in August 2018 and therefore not validated. The Post-Partum Care and Provider Satisfaction PIPs were validated using the *CMS Protocol for Validation of Performance Improvement Projects*. Both projects received a score within the "High Confidence in Reported Results" range and met the validation requirements. *Table 3, Performance Improvement Project Validation Scores* provides an overview of the validation scores.

TABLE 3: Performance Improvement Project Validation Scores

PROJECT	2017 VALIDATION SCORE	2018 VALIDATION SCORE
Improving Dilated Retinal Exam (DRE) Screening	131/131=100% High Confidence in Reported Results	Retired August 2018
Post-Partum Care	Not Validated	98/98=100% High Confidence in Reported Results
Member Satisfaction	120/126=95% High Confidence in Reported Results	Retired August 2018
Provider Satisfaction	Not Validated	87/88=99% High Confidence in Reported Results

Utilization Management:

CCME's assessment of utilization management (UM) includes reviews of program descriptions, program evaluations, policies, *Member Handbook, Provider Manual*, approval, denial, appeal and case management files, and the ATC website. Policies and procedures define how UM, medical necessity determinations, appeals, and CM services are operationalized and provided to members.

The *UM Program Description* outlines the purpose, goals, objectives, and staff roles for physical and behavioral health. CCME identified issues with timeframes for member-requested extensions of expedited service authorizations. CCME also found minor issues repeated in several documents related to appeals, such as documenting two separate timelines for when the appeal process begins, inconsistent calendar days defining when receipt of written confirmation is required, and incorrect reference to the term adverse benefit determination in a pharmacy policy.

The *Care Management Program Description* and policies appropriately document case management processes and services provided. However, the program description does not address referrals for Targeted Case Management for alcohol and substance abuse individuals, children in foster care, and children in the juvenile justice system. Refer to the *SCDHHS Contract, Section 4.2.27* and the *SCDHHS Policy and Procedure Guide for Managed Care Organizations* under Targeted Case Management Services (page 42). During the onsite visit, ATC reported children in foster care are not enrolled in ATC. Additionally, ATC shared positive highlights regarding the water delivery initiative for members in the Sick Cell Case Management Program. ATC does not have a designated Transition Coordinator as required by the *SCDHHS Contract, Section 5.6.2.*

Overall, review of UM approval, appeals, and denial files provided evidence that appropriate processes are followed. Care Management files indicate care gaps are identified and addressed consistently and services are provided for various risk levels.

Delegation:

ATC delegates various functions to Envolve PeopleCare (behavioral health, disease management, nurse hotline, vision, and pharmacy) and National Imaging Associates (radiology) through their national delegation program; the program includes annual oversight. Envolve PeopleCare is a wholly-owned subsidiary of Centene Corporation, and ATC staff reported that even though oversight will be conducted, they may not be considered delegated functions in the future. Onsite discussion confirmed some of the BH related services conducted by Envolve PeopleCare transitioned back to the health plans in 2018.

Credentialing delegation is addressed in *Policy CC.CRED.12* and CCME identified a few issues in *Attachment J* and *Exhibit B* relating to not addressing all the queries required by SCDHHS Program Integrity, inconsistent health plan specific elements between *Exhibit B* and the current oversight tool, and not specifying that annual audits are required regardless of the delegated entity's accreditation status.

CCME found a few concerns in its review of ATC's oversight conducted for the 12 entities where credentialing is delegated. ATC does not appear to have a clear process for following up on deficiencies found in the annual oversight audit. This is evidenced by letters that do not mention whether a Corrective Action Plan (CAP) is required or a date by which the CAP items need to be addressed. In some cases, the annual oversight letter indicates a score of 100%, yet corrective action items are documented. And finally, some of the queries required by SCDHHS Program Integrity were not evaluated in the annual oversight file review.

State Mandated Services:

Provider compliance with provision of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and required immunizations is monitored through medical record reviews conducted by nurse reviewers. ATC provides all core benefits specified by the *SCDHHS Contract*.

*Table 4, Scoring Ove*rview provides an overview of the findings of the current annual review as compared to the findings of the 2017 review.

Table 4: Scoring Overview

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
Administration						
2017	39	0	0	0	0	39
2018	39	1	0	0	0	40
Provider Services						
2017	71	4	3	0	0	78
2018	72	6	0	0	0	78
Member Services						
2017	30	2	0	0	0	32
2018	32	1	0	0	0	33
Quality Improvement						
2017	15	0	0	0	0	15
2018	14	1	0	0	0	15
Utilization						
2017	44	1	0	0	0	45
2018	43	1	1	0	0	45
Delegation						
2017	1	1	0	0	0	2
2018	1	1	0	0	0	2
State Mandated Services						
2017	4	0	0	0	0	4
2018	4	0	0	0	0	4

METHODOLOGY

The process used by CCME for the EQR activities is based on protocols developed by the Centers for Medicare & Medicaid Services (CMS) for the external quality review of a Medicaid MCO/PIHP and focuses on the three federally mandated EQR activities of compliance determination, validation of performance measures, and validation of performance improvement projects (PIPs).

On December 3, 2018, CCME sent notification to ATC that it was initiating the Annual EQR (see Attachment 1). This notification included a list of materials required for a desk review and an invitation for a teleconference to allow ATC to ask questions regarding the EQR process and the desk materials being requested.

The review consists of two segments. The first is a desk review of materials and documents received from ATC on December 17, 2018 and reviewed in the offices of CCME (see Attachment 1). These items focus on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement and Medical Management Programs. Also included in the desk review is a review of credentialing, grievance, utilization, case management, and appeal files.

The second segment is an onsite review conducted on February 28, 2019 and March 1, 2019 at ATC's office located in Columbia, SC. The onsite visit focused on areas not covered in the desk review or areas needing clarification. See Attachment 2 for a list of items requested for the onsite visit. Onsite activities included an entrance conference, interviews with ATC's administration and staff, and an exit conference. All interested parties were invited to the entrance and exit conferences.

FINDINGS

The findings of the EQR are summarized below and are based on the regulations set forth in *Title 42 of the Code of Federal Regulations (CFR), part 438*, and the contract requirements between ATC and SCDHHS. Strengths, weaknesses and recommendations are identified where applicable. Areas of review are identified as meeting a standard (Met), acceptable but needing improvement (Partially Met), failing a standard (Not Met), Not Applicable, or Not Evaluated, and are recorded on the tabular spreadsheet (Attachment 4).

A. Administration

Absolute Total Care (ATC) is a subsidiary of Centene Corporation (Centene), headquartered in St. Louis, Missouri. John McClellan is ATC's President and Chief Executive Officer, responsible for the health plan's day-to-day business activities and

accountable to the Board of Directors and Centene. The review of the organizational chart and staffing reveals all contractually required positions are filled; however, one staff member is serving as both Senior Vice President of Quality Improvement and Interim Vice President of Medical Management. CCME confirmed during onsite discussion that ATC is recruiting for the Vice President of Medical Management position but has no estimation of when it will be filled. ATC has additional staffing vacancies and has recruitment and hiring activities in process for all.

Policies are organized by department or functional area within the health plan and reviewed annually. The Archer Policy Management system is used to house and manage policies and provides a centralized location for staff to access policies. In addition to local plan policies, corporate policies are used sometimes and typically contain appendices or addenda to define South Carolina requirements and processes.

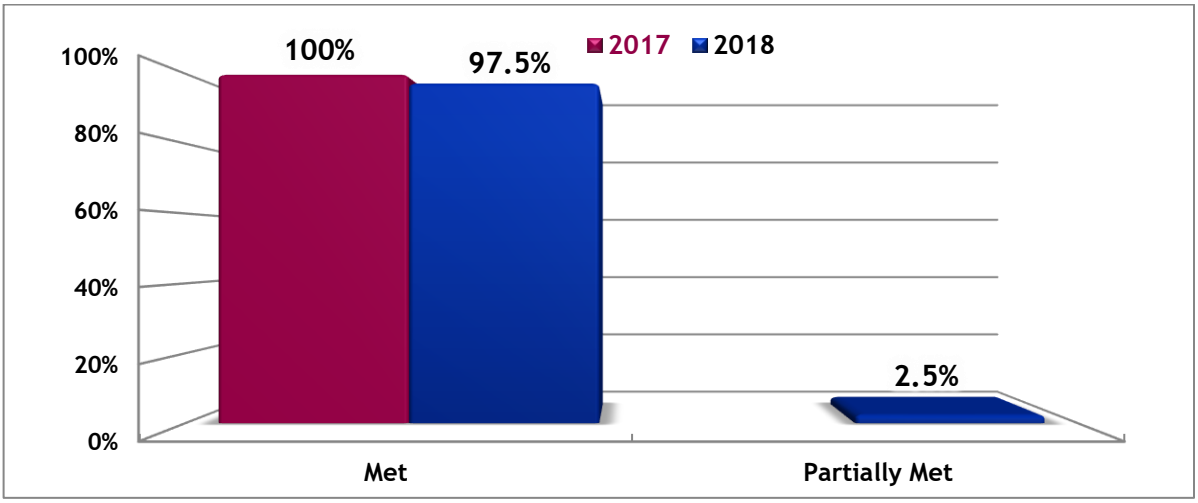
ATC's *Information Systems Capabilities Assessment* documentation demonstrates the plan is committed to the fundamentals of data security (confidentiality, integrity, and availability). The focus on data confidentiality is reflected in policies and procedures, and an emphasis on data integrity and availability is reflected in the disaster recovery plan. The disaster recovery plan was tested and was completed successfully within the allotted recovery timeframe. ATC and Centene are commended for continuing to perform remote location disaster recovery testing while many organizations perform more abbreviated tabletop recovery exercises.

The *Compliance and Ethics Program Description*, *Fraud, Waste and Abuse Plan*, and supplemental policies provide information about ATC's expectation that staff comply with standards of conduct and processes for detecting and preventing fraud, waste, and abuse. ATC provides staff, members, network providers, and other applicable parties (subcontractors, etc.) with appropriate information about reporting suspected or actual compliance violations as well as fraud, waste, and abuse. Confidential reporting is assured, and ATC follows a "no retaliation" policy. Staff are required to complete compliance training at the time of hire and annually thereafter. All staff must complete an annual *Conflict of Interest* disclosure. Issues identified in the areas of Compliance and Program Integrity include:

- All queries required for exclusion status monitoring are either not addressed or are incomplete or inaccurate in the *Fraud, Waste, and Abuse Plan* and the *Monthly Employee, Vendor, and Board Member Exclusion Screening* policy.
- The *Annual Compliance Training* policy indicates staff receive training on privacy and confidentiality within 10 days of initial employment. CCME encourages ATC to revise the policy to include information that states confidentiality training is provided prior to granting staff access to protected health information.

Figure 2, Administration Findings indicates 97.5% of the Administration standards are scored as "Met." Scores of "Partially Met" are related to documentation of exclusion status monitoring.

Figure 2: Administration Findings



Strengths

- ATC filled several positions recently and continues to recruit candidates for vacant positions.
- ATC has concise information systems policies and procedures and a thorough disaster recovery plan.
- ATC and Centene perform actual system recovery tests, while many companies perform only tabletop recovery reviews.

Weaknesses

- ATC did not provide actual clean claims payment performance for 30 and 90 days, but *Information Systems Capabilities Assessment* documentation states claims are audited regularly.
- The *Compliance and Ethics Program Description* contains a reference to *Policy CC.HUMR.17, Discipline*. The title of *Policy CC.HUMR.17* is "Performance Management" rather than "Discipline."
- The following do not address all queries required for exclusion status monitoring or the information is incomplete or inaccurate:
  - *Attachment Q* (page 90) of the *Fraud, Waste, and Abuse Plan* mentions checking providers and subcontractors at enrollment against the General Services Administration's Excluded Parties List Service. There is no mention of checking this

at any time other than at enrollment. Of note, the Excluded Parties List Service was changed to the System for Award Management in 2012.

  - *Policy CC.COMP.36, Monthly Employee, Vendor, and Board Member Exclusion Screening* does not address the Social Security Administration's Death Master File or the databases required by SCDHHS Program Integrity: the SC List of Providers Terminated for Cause, Suspended List, Behavioral Health Actions List, and Excluded Provider List.

- Compliance Committee minutes for 2018 reveal the second quarter meeting was not held until the third quarter. ATC provided an explanation during onsite discussion.
- The following documents contain discrepancies in the membership of the Compliance Committee:
  - *Compliance Committee Charter*
  - *2018 Compliance Committee Members* list
  - *Compliance and Ethics Program Description* (page 7)
  - *Compliance Committee Agenda* (September 28, 2018)
- *Policy SC.FINC.02, Post-Payment Recovery Requirement* states the purpose of the policy is to outline the procedure for post-payment recouping but provides minimal information. It states, "If a claim is recouped in full any encounters for that claim will be voided. If there is an adjusted claim a replacement encounter will be submitted for the adjusted claim."
- Page one of *Policy CC.COMP.10, Annual Compliance Training* states employees receive training about privacy and confidentiality of individual health information within 10 days of initial employment. CCME confirmed during onsite discussions that confidentiality training is provided on the first day of employment prior to granting access to protected health information.

Quality Improvement Plans

- Revise *Policy CC.COMP.36* and *Attachment Q* of the *Fraud, Waste, and Abuse Plan* to include all required queries and the frequency of all queries conducted to ensure employees, providers, and subcontractors are eligible to participate in Federal health care programs.
- Correct the reference to the Excluded Parties List Service in *Attachment Q* of the *Fraud, Waste, and Abuse Plan*.

Recommendations

- Include actual 30-day and 90-day clean claims payment performance in future *Information Systems Capabilities Assessment* review documentation.

- In the *Compliance and Ethics Program Description* (page nine), update the reference to *Policy CC.HUMR.17* with the correct policy name.
- Ensure Compliance Committee meetings are held quarterly, as required by the *Compliance Committee Charter*. If a meeting is not held or is held late, document the reason.
- Revise all documents that list the membership of the Compliance Committee so that the information is consistent.
- Revise *Policy SC.FINC.02* to include full information about procedures for post-payment recoupment to fulfill the stated purpose of the policy.
- Revise *Policy CC.COMP.10* to include a statement that all employees receive confidentiality training prior to receiving access to protected health information.

B. Provider Services

CCME conducted a review of all ATC Provider Services policies, procedures, the provider agreement, provider training and educational materials, provider network information, credentialing/recredentialing files, and practice guidelines.

The Credentialing Committee meets monthly and is chaired by Dr. Robert Thompson, Medical Director. Additional voting members include four network providers with specialties in pediatrics, surgery, and psychiatry. Dr. Cheryl Walker-McGill, Medical Director, serves as an alternate and attends meetings rarely. Meeting minutes showed the quorum of two thirds of voting members was met at each meeting.

ATC's comprehensive credentialing program is defined in several policies. The policies and credentialing/recredentialing files do not include all of the queries required by SCDHHS Program Integrity, such as the Suspended List and the Behavioral Health Actions List. ATC confirmed during the onsite discussion that credentialing and recredentialing of behavioral health providers is no longer conducted by Envolve PeopleCare (formally Cenpatico); these functions are integrated in to the regular credentialing process conducted for the local health plan.

ATC adopts clinical and preventive practice guidelines for the provision of acute, chronic, and behavioral health services relevant to the populations served. Current preventive and clinical practice guidelines are available on the ATC provider website and can be mailed to practitioners as part of disease management or other quality program initiatives. The adopted clinical practice guidelines reflect inconsistencies between the website and *Provider Manual*.

Provider Access and Availability Study

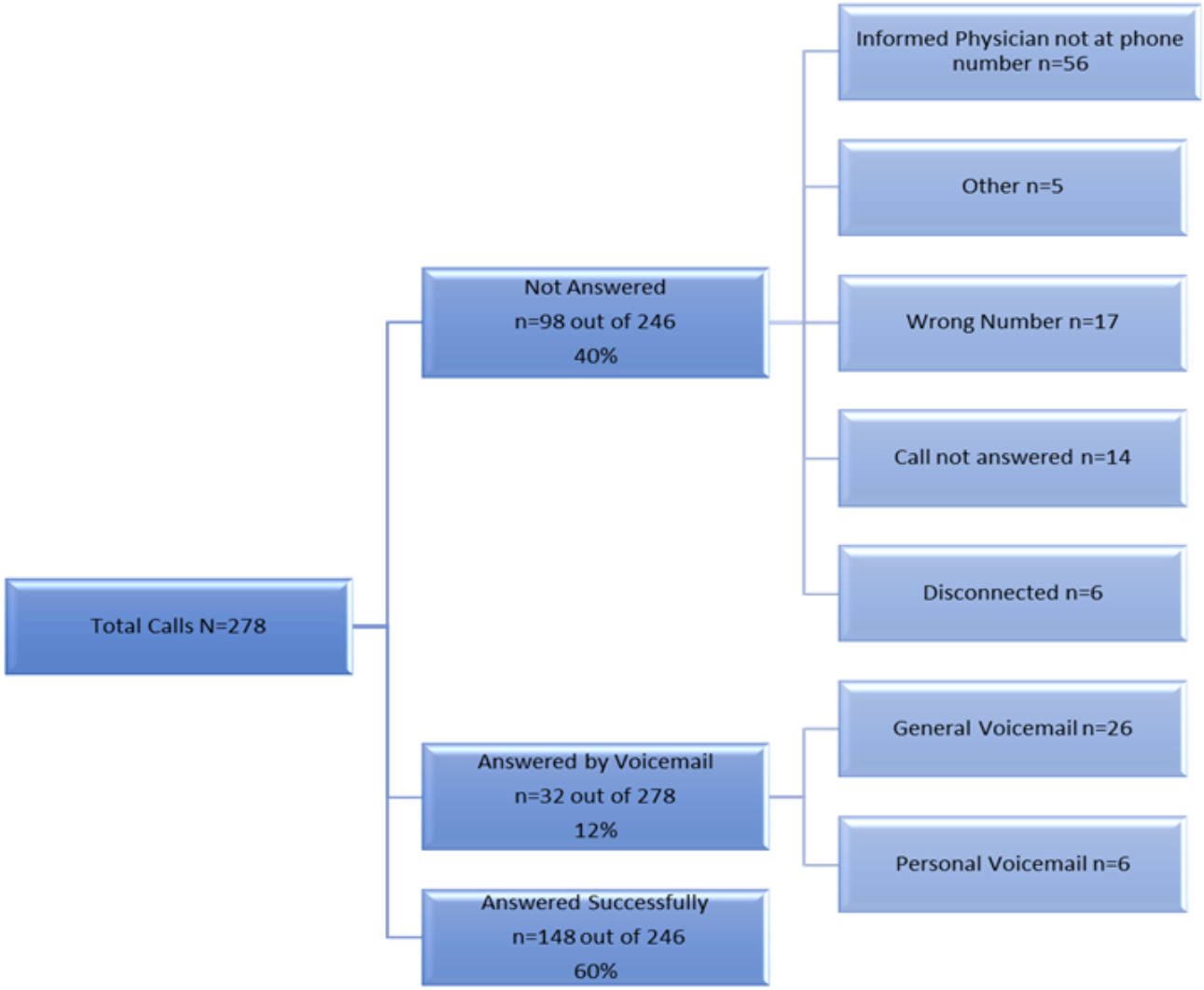
As part of the Annual EQR process for ATC, CCME conducted a provider access study focused on primary care providers. ATC gave CCME a list of current providers, from which a population of 2,878 unique primary care providers (PCPs) was found. A sample of 278 providers was randomly selected from the total population for the access study. Attempts were made to contact these providers to ask a series of questions regarding the access that members have with the contracted providers. The results of the *Telephonic Provider Access Study*, conducted by CCME, demonstrated calls were answered successfully 60% of the time (148 out of 246) when omitting calls answered by personal or general voicemail messaging services. When compared to 2017 results of 51%, 2018 has a marginally significant increase in successful calls at 60% (p=.0526) as shown in *Table 5: Telephonic Access Study Answer Rate Comparison*.

Table 5: Telephonic Access Study Answer Rate Comparison

	Sample Size	Answer Rate	Fisher's Exact P-value
2017 Review	300	51%	.0526
2018 Review	278	60%	

Figure 3: Telephonic Provider Access Study Results provides an overview of the *Telephonic Provider Access Study* results.

Figure 3. Provider Access Study Results



For calls not answered successfully (n=98 calls), 56 (57%) were unsuccessful because the provider was not at the office or phone number listed. Of the 148 providers, 132 (89%) indicated they accept ATC, with five (3%) indicating this occurred only under certain conditions. Of 129 responses, 100 (78%) providers responded they are accepting new Medicaid patients.

Regarding a screening process for new patients, 61 (59%) of the 104 providers who responded to the item indicated that an application or prescreen was necessary, with 13 (21%) indicating that an application must be filled out, whereas 14 (23%) require a review of medical records before accepting a new patient, and 19 (31%) require both. When the

office was asked about the next available routine appointment, 63 (76%) of the 83 responses met contract requirements.

Figure 4: Provider Services Findings shows 92% of the standards in Provider Services received a "Met" score. *Table 6, Provider Services Comparative Data* highlights changes in scores from 2017 to 2018.

Figure 4: Provider Services Findings

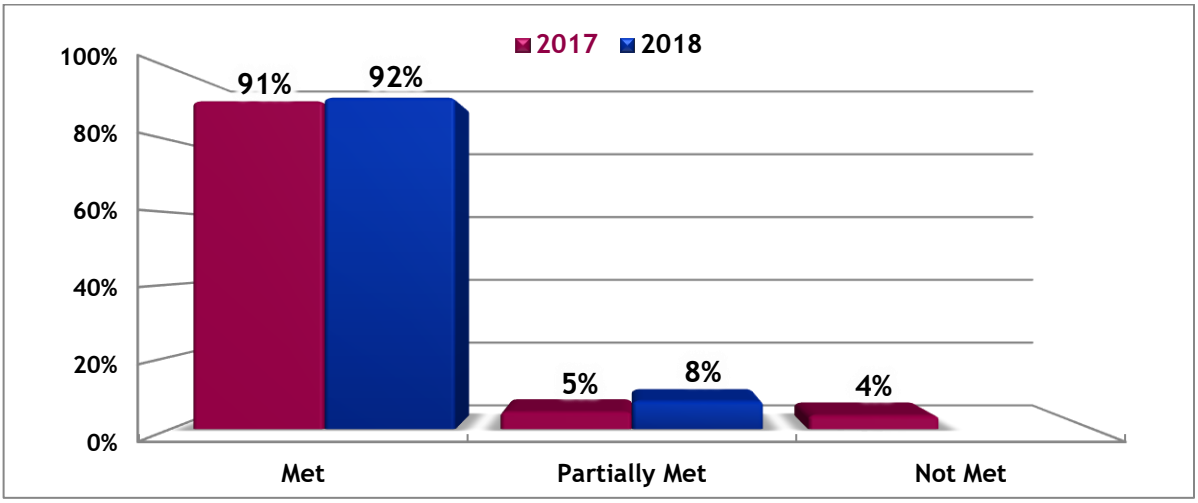


Table 6: Provider Services Comparative Data

SECTION	STANDARD	2017 REVIEW	2018 REVIEW
Credentialing and Recredentialing	Credentialing: Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause list, and the CMS Adverse Action Report List	Not Met	Partially Met
	Query of Social Security Administration's Death Master File (SSDMF)	Partially Met	Met
	Recredentialing: Requery of the State Excluded Provider's Report, the SC Providers Terminated for Cause list, and the CMS Adverse Action Report List	Not Met	Partially Met
	Query of Social Security Administration's Death Master File (SSDMF)	Partially Met	Met

SECTION	STANDARD	2017 REVIEW	2018 REVIEW
Credentialing and Recredentialing	Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities	Not Met	Partially Met
Primary and Secondary Preventive Health Guidelines	The MCO communicates the clinical practice guidelines for disease, chronic illness management, and behavioral health services and the expectation that they will be followed for MCO members to providers	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2017 to 2018.

Strengths

- The ATC website is user-friendly and contains a wealth of provider resource information such as the *Provider Manual*, practice guidelines, newsletters, forms, training, etc.
- The *Telephonic Provider Access Study* success rate increased 9% from the 2017 study results.

Weaknesses

- *Policy CC.CRED.01, Practitioner Credentialing & Recredentialing* has the following issues:
  - Page 31, footnote 87 incorrectly references the South Carolina 2016 MCO Contract.
  - Page 20 (footnote 52) and *Attachment J* do not address all Program Integrity (PI) queries required by SCDHHS, such as the Suspended List and the Behavioral Health Actions List.
- Credentialing and recredentialing files do not show evidence the following PI queries required by SCDHHS were performed: Suspended List and Behavioral Health Actions List.
- One credentialing file did not contain a copy of the Clinical Laboratory Improvement Amendment (CLIA) certificate even though the provider indicated on the application that laboratory services were provided.
- One recredentialing file did not contain a copy of the query of the National Plan and Provider Enumeration System (NPPES).
- *Policy CC.CRED.09, Organizational Assessment and Reassessment* does not address all the PI queries required by SCDHHS, such as the Suspended List and the Behavioral Health Actions List.

- *Policy CC.CRED.06, Ongoing Monitoring of Sanctions & Complaints* does not address all the PI queries required by SCDHHS, such as the Suspended List, and the Behavioral Health Actions List.
- The adopted clinical practice guidelines reflect inconsistencies between the website and *Provider Manual*:
  - The *Provider Manual*, page 26, shows "Quick Reference Guide Clinical Practice Guidelines for Standards of Medical Care in Diabetes – 2015," but the website shows "Diabetes Care: Standards of Medical Care in Diabetes, 2018."
  - The *Provider Manual*, page 27, shows "Diabetic Care: Summary of Revisions for the 2012 Practice Recommendations," but the website shows "Standards of Medical Care in Diabetes, 2018: Summary of Revisions."
  - The *Provider Manual*, page 26, lists "Physician Guidelines for Routine Antepartum Care," but this is not listed on the website.
  - The following guidelines are listed on the website but not mentioned in the *Provider Manual*: "Practice Parameter for the Assessment and Treatment of Children and Adolescents with Bipolar Disorder" and "Practice Guideline for the treatment of Patients with Substance Use Disorders."

Quality Improvement Plans

- Update *Policy CC.CRED.01, Practitioner Credentialing & Recredentialing* to correct the 2016 MCO Contract reference and ensure all the PI queries required by SCDHHS are addressed in the policy.
- Ensure credentialing and recredentialing files contain proof of all PI queries required by SCDHHS.
- Update *Policy CC.CRED.09, Organizational Assessment and Reassessment, Attachment M* to include the Suspended List and the Behavioral Health Actions List as required queries.
- Update *Policy CC.CRED.06, Ongoing Monitoring of Sanctions & Complaints, Attachment J* to include the Suspended List and the Behavioral Health Actions List as required queries.
- Update the Provider Manual or the website to ensure all clinical practice guidelines are accurately reflected.

Recommendations

- For credentialing and recredentialing, ensure CLIA certificates are collected for providers who indicate they provide laboratory services.
- Ensure credentialing and recredentialing files contain proof of query of the NPPES.

C. Member Services

The review of Member Services encompasses member rights; member education about the health plan, benefits, and services; enrollment and disenrollment; preventive health and chronic disease management education; the *Member Satisfaction Survey*; and grievances.

Member education about the health plan is primarily provided through the *Member Handbook*. New members receive a packet of information at enrollment that includes the *Member Handbook*, *Provider Directory*, and a list of frequently asked questions. Members are encouraged to contact Member Services if they have questions about the health plan, benefits, providers, etc. Quarterly member newsletters provide supplemental information about benefits and additional information about various topics of interest to members; e.g., community events, preventive health care, the Member Portal, etc. After reviewing member educational materials, CCME provided suggestions for ways to improve or clarify the information presented.

Member rights and processes for informing members of their rights are defined in policy. Information about member rights is included in the *Member Handbook*, *Provider Manual*, ATC's website, and member newsletters. Network providers are required to post member rights in their offices in areas visible to members.

The *Member Handbook* provides a list of preventive health guidelines and refers members to the website to view the guidelines. CCME noted the web page containing the preventive health guidelines may be difficult for members to locate, and that the page includes a clinical practice guideline for substance use disorder that should be moved to another page on the website. ATC encourages members to obtain recommended preventive services, including well-child services, through the *Member Handbook*, mailings, telephonic outreach, and materials placed in provider offices. The Member Connections Program provides members with face-to-face contact in the member's home or community to educate members about healthy lifestyle, risk factors, etc.

Morpace, a certified Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey vendor, conducts member satisfaction surveys for ATC. When compared to the 2017 survey, the response rate for the Child survey is unchanged, and both the Adult and Children with Chronic Conditions response rates decreased. CCME offered suggestions to improve future survey response rates. Reporting of survey results to appropriate committees and to network providers is evident.

Processes for grievance handling and resolution are well-documented throughout policies, the *Member Handbook*, *Provider Manual*, and on the website. The grievance policy (*SC.UM.11*) references a process for clinically urgent grievances but does not provide a thorough explanation of this process. CCME encourages ATC to expand the information in

the policy to fully explain this internal process. CCME's review of grievance files found a concern related to provider re-education about plan processes and requirements—particularly related to the requirement that pharmacies must issue members a limited emergency supply of medications that require prior authorization. The files do not contain documentation that education was provided by grievance staff or that referrals were made to other departments or entities to provide the needed education.

As noted in the following chart, 97% of the standards for Member Services are scored as "Met." One standard is scored as Partially Met due to lack of provider re-education found during the grievance file review.

Figure 5: Member Services Findings

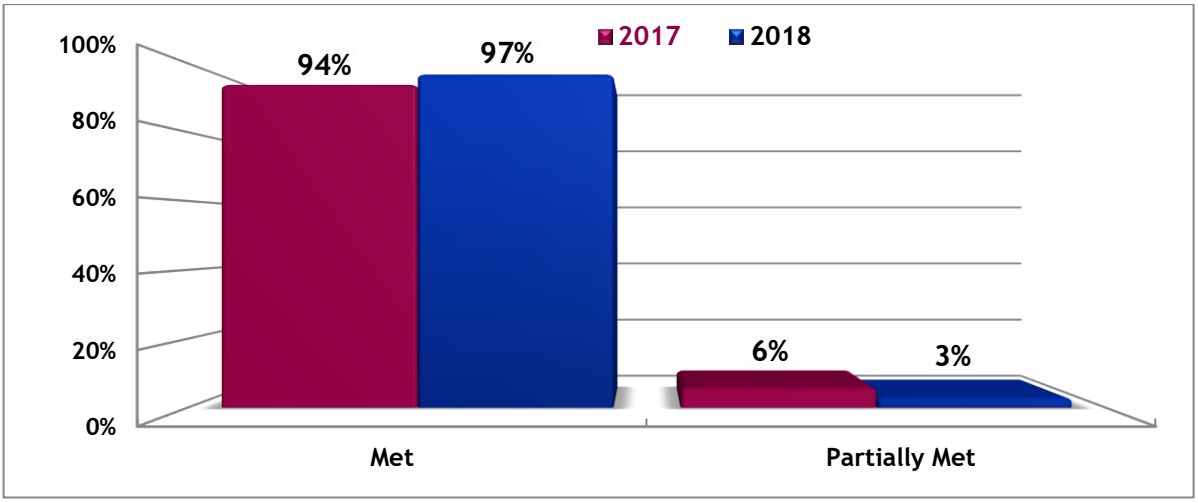


Table 7: Member Services Comparative Data

SECTION	STANDARD	2017 REVIEW	2018 REVIEW
Member MCO Program Education	Members are informed in writing within 14 calendar days from the MCO's receipt of enrollment data of all benefits and MCO information	Partially Met	Met
Grievances	The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to procedures for filing and handling a grievance	Partially Met	Met

SECTION	STANDARD	2017 REVIEW	2018 REVIEW
Grievances	Timeliness guidelines for resolution of a grievance	Partially Met	Met
	The MCO applies grievance policies and procedures as formulated	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2017 to 2018.

Strengths

- The "Member Resources" section of ATC's website contains a wealth of information for members, including forms, handbooks, information about the Member Advisory Council, and links to external resources including the Women, Infants and Children (WIC) Program; Big Brothers, Big Sisters; and the National Hospice and Palliative Care Organization; and more.
- ATC's CentAccount® Rewards Program incentivizes members to complete healthy behaviors such as completing the Health Risk Screening, having annual check-ups, getting flu shots, etc. Rewards can be used at a variety of retailers to purchase groceries, over-the-counter, medications, baby care items, personal care items, etc.

Weaknesses

- The benefits grid in the *Member Handbook* (page 19) addresses maternity services and the "Limitations" column states, "OB/GYN visits, etc." Members may misinterpret this to mean that ATC limits the number of OB/GYN visits, etc.
- The benefits grids in the *Member Handbook* and *Provider Manual* list "$0" for services that have no copayment; however, in both documents the copayment field for infusion centers is blank. CCME confirmed there is no copayment for infusion centers during the onsite visit.
- The *SCDHHS Contract, Section 5.6.6.4* requires health plans to make a good faith effort to give written notice of the termination of a contracted provider to applicable members within 15 days after receipt or issuance of a termination notice. *Policy SC.ELIG.14, Member Notification of Provider Termination* appropriately documents the timeframe as stated in the *SCDHHS Contract*; however, timeframes documented in the following policies are inconsistent with the timeframe documented in *Policy SC.ELIG.14*:
  - *Policy SC.MBRS.12, Enrollee Notification* defines the timeframe as at least 30 days before the change is effective.

  - *Policy CC.PRVR.23, Provider Termination Policy* states the timeframe is at least 30 days prior to the effective date of the change, or otherwise as soon as feasible based on receipt of notice.

- Members may have difficulty locating preventive health guidelines on ATC's website in their current location (under the "Quality Improvement Program" section of the "Member Resources" area).
- The "Preventive Guidelines" web page in the "Member Resources" area of the website includes *Practice Guideline for the Treatment of Patients with Substance Use Disorders*, which is a clinical practice guideline rather than a preventive health guideline.
- The response rate for the Child CAHPS survey is unchanged at 22%, which is the national average rate. The Adult response rate is 19%, which is a decrease from the 2017 rate of 25%. The Children with Chronic Conditions response rate decreased to 20% from the 2017 rate of 22% for the total sample response rate.
- *Policy SC.UM.11, Member Grievances* mentions a clinically urgent grievance process but does not provide enough information to fully understand the process. Onsite discussion revealed this is an internal process and members cannot request expedited processing of grievances. Staff can make the determination that a grievance is clinically urgent if the grievance involves medical issues.
- A common issue identified during CCME's review of grievance files is related to lack of referrals for provider re-education:
  - In three of the grievance files, members requested reimbursement for the cost of medications. For each of the three, the pharmacy failed to provide an emergency supply of medication that required prior authorization and required out-of-pocket payment from the members for the medication. Each of the members met with difficulty receiving reimbursement for the medications from ATC. There is no information in the files to indicate a referral was made to an appropriate ATC department or to Envolve Pharmacy Solutions to provide pharmacy re-education about the requirement to provide an emergency supply of medication.
  - One grievance was related to a provider's refusal to release the member's medical records due to a past-due balance. While the file notes did indicate that per *South Carolina Code of Laws, Section 44-115-70*, records are not to be withheld because of unpaid medical bills, there is no indication in the file that the provider was educated about this requirement or that a referral was made to an appropriate department to re-educate the provider. In addition, this file was investigated as a balance-billing issue rather than the issue of refusal to provide medical records, and the resolution notice does not address the member's complaint.

Quality Improvement Plans

- When the need for provider re-education regarding plan policies and program requirements is identified, ensure grievance files contain documentation of re-education conducted by grievance staff or referrals to other appropriate departments to provide re-education.
- Ensure grievance investigations and resolutions address the issue about which the member filed the grievance.

Recommendations

- Revise the information in the *Member Handbook's* benefit grid "Limitations" column for maternity services to remove the statement, "OB/GYN visits, etc." or explain any applicable limitations.
- Revise the tables in the *Member Handbook* (page 18) and *Provider Manual* (page 44) to indicate there is no copay for infusion centers.
- Review and revise *Policy SC.ELIG.14*, *Policy SC.MBRS.12*, and *Policy CC.PRVR.23* as needed to clarify inconsistencies in the timeframes for member notification of provider termination.
- Place preventive health guidelines in a more prominent location on the website to allow members to locate them easily.
- Remove *Practice Guideline for the Treatment of Patients with Substance Use Disorders* from the list of preventive health guidelines on the website.
- Because low CAHPS survey response rates affect generalizability of results, continue working with the vendor to increase response rates. Consider other options such as adding reminders to the call center and maximizing oversampling to increase response rates.
- Revise *Policy SC.UM.11* to fully explain the clinically urgent grievance process. Include information such as how determinations are made that a grievance is clinically urgent, who makes the determination that a grievance is clinically urgent, etc.

D. Quality Improvement

For the Quality Improvement (QI) section, CCME reviewed the *2018 Quality Assessment and Performance Improvement Description Medicaid,* committee structure and minutes, performance measures, performance improvement projects, and the QI program evaluation. ATC's *2018 Quality Assessment and Performance Improvement Program Description Medicaid* describes the program's quality improvement structure, function, scope, and goals as defined by the health plan. The Board of Directors (BOD) provides strategic direction and final authority for the QI Program. The BOD has delegated the

operational responsibility for the program to the Quality Improvement Committee (QIC). This committee meets at least quarterly. Minutes are drafted for each meeting, reviewed, and approved at the next regularly scheduled meeting. ATC submitted QIC minutes for meetings held in March 2018 – August 2018 for review.

ATC reviewed and adopted several Clinical and Preventive Practice Guidelines. Network providers are informed of the guidelines and the expectation that the guidelines are followed. At least annually, ATC measures provider compliance with the guidelines. The monitoring processed used by ATC is described in *Policy SC.QI.08, Clinical & Preventive Practice Guidelines*. The policy states "ATC measures practitioner compliance with at least two measures for each of the four clinical guidelines." The policy further indicates a total score of 80% compliance must be met or a corrective action plan is required. Results of monitoring were only found for Diabetes, Asthma, and Well Child Visits. Diabetes and Asthma results show the providers met the 80% compliance rate; however, the goal set for the Well Child Visits did not follow ATC's policy of 80% compliance. This goal was set at the 75th Quality Compass percentile. The results fell below this goal and ATC did not document corrective action. CCME recommends updating the policy to better reflect the monitoring process or follow the current monitoring process outlined in the policy.

ATC evaluates the effectiveness of their QI Program annually. For this review, the health plan provided the *Quality Assessment and Performance Improvement Program Evaluation – Medicaid 2017*. This report provides an assessment of the results of the QI activities conducted in 2017.

Performance Measure Validation

CCME conducted a validation review of the HEDIS measures following Centers for Medicare & Medicaid Services (CMS) protocols. This process assesses the production of these measures by the health plan to confirm reported information is valid.

ATC uses Inovalon, a certified software organization, for calculation of HEDIS rates and met the validation requirements. The 2018 rate, the 2017 rate, and the change in rate are presented in *Table 8: HEDIS Performance Measure Data*.

Table 8: HEDIS Performance Measure Data

MEASURE/DATA ELEMENT	HEDIS 2017	HEDIS 2018	PERCENTAGE POINT DIFFERENCE
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	87.35%	87.83%	0.48%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			

MEASURE/DATA ELEMENT	HEDIS 2017	HEDIS 2018	PERCENTAGE POINT DIFFERENCE
BMI Percentile	68.75%	79.56%	10.81%
Counseling for Nutrition	56.01%	67.40%	11.39%
Counseling for Physical Activity	44.71%	63.02%	18.31%
Childhood Immunization Status (cis)			
DTaP	78.61%	75.43%	-3.18%
IPV	91.35%	89.54%	-1.81%
MMR	91.59%	89.29%	-2.30%
HiB	86.06%	83.70%	-2.36%
Hepatitis B	93.03%	89.78%	-3.25%
VZV	92.55%	89.54%	-3.01%
Pneumococcal Conjugate	81.97%	78.10%	-3.87%
Hepatitis A	86.78%	84.91%	-1.87%
Rotavirus	73.80%	74.70%	0.90%
Influenza	43.51%	42.82%	-0.69%
Combination #2	76.68%	72.02%	-4.66%
Combination #3	75.48%	69.83%	-5.65%
Combination #4	72.60%	66.91%	-5.69%
Combination #5	64.18%	61.31%	-2.87%
Combination #6	38.70%	38.44%	-0.26%
Combination #7	62.98%	59.85%	-3.13%
Combination #8	38.22%	37.96%	-0.26%
Combination #9	34.38%	36.01%	1.63%
Combination #10	33.89%	35.52%	1.63%
Immunizations for Adolescents (ima)			
Meningococcal	69.23%	72.75%	3.52%
Tdap/Td	83.89%	85.64%	1.75%
Combination #1	67.79%	71.53%	3.74%
Combination #2	22.60%	30.17%	7.57%
Human Papillomavirus Vaccine for Female Adolescents (hpv)	24.28%	31.63%	7.35%
Lead Screening in Children (lsc)	68.51%	67.40%	-1.11%
Breast Cancer Screening (bcs)	60.50%	62.88%	2.38%
Cervical Cancer Screening (ccs)	61.92%	66.18%	4.26%
Chlamydia Screening in Women (chl)			

MEASURE/DATA ELEMENT	HEDIS 2017	HEDIS 2018	PERCENTAGE POINT DIFFERENCE
16-20 Years	55.14%	55.24%	0.10%
21-24 Years	65.08%	65.17%	0.09%
Total	58.53%	58.52%	-0.01%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)	74.30%	78.31%	4.01%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	27.33%	26.85%	-0.48%
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	56.65%	55.56%	-1.09%
Bronchodilator	83.43%	78.46%	-4.97%
Medication Management for People With Asthma (mma)			
5-11 Years - Medication Compliance 50%	47.96%	51.77%	3.81%
5-11 Years - Medication Compliance 75%	20.43%	23.31%	2.88%
12-18 Years - Medication Compliance 50%	43.52%	48.83%	5.31%
12-18 Years - Medication Compliance 75%	20.47%	22.30%	1.83%
19-50 Years - Medication Compliance 50%	45.60%	56.52%	10.92%
19-50 Years - Medication Compliance 75%	25.27%	31.68%	6.41%
51-64 Years - Medication Compliance 50%	64.10%	62.22%	-1.88%
51-64 Years - Medication Compliance 75%	33.33%	42.22%	8.89%
Total - Medication Compliance 50%	46.67%	51.75%	5.08%
Total - Medication Compliance 75%	21.62%	24.72%	3.10%
Asthma Medication Ratio (amr)			
5-11 Years	74.75%	82.58%	7.83%
12-18 Years	60.33%	67.36%	7.03%
19-50 Years	49.56%	53.36%	3.80%
51-64 Years	62.50%	60.66%	-1.84%
Total	65.18%	71.93%	6.75%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	35.88%	40.88%	5.00%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	65.38%	51.35%	-14.03%
Statin Therapy for Patients With Cardiovascular Disease (spc)			
Received Statin Therapy - 21-75 years (Male)	69.36%	76.64%	7.28%

MEASURE/DATA ELEMENT	HEDIS 2017	HEDIS 2018	PERCENTAGE POINT DIFFERENCE
Statin Adherence 80% - 21-75 years (Male)	34.36%	41.46%	7.10%
Received Statin Therapy - 40-75 years (Female)	66.31%	70.06%	3.75%
Statin Adherence 80% - 40-75 years (Female)	29.84%	30.65%	0.81%
Received Statin Therapy - Total	68.01%	73.66%	5.65%
Statin Adherence 80% - Total	32.40%	36.81%	4.41%
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)			
Hemoglobin A1c (HbA1c) Testing	88.37%	89.23%	0.86%
HbA1c Poor Control (>9.0%)	47.40%	49.45%	2.05%
HbA1c Control (<8.0%)	41.49%	40.88%	-0.61%
Eye Exam (Retinal) Performed	54.34%	52.19%	-2.15%
Medical Attention for Nephropathy	93.06%	93.80%	0.74%
Blood Pressure Control (<140/90 mm Hg)	46.88%	40.88%	-6.00%
Statin Therapy for Patients With Diabetes (spd)			
Received Statin Therapy	55.76%	59.04%	3.28%
Statin Adherence 80%	33.92%	37.58%	3.66%
Effectiveness of Care: Musculoskeletal Conditions			
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	65.55%	61.83%	-3.72%
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	36.81%	39.15%	2.34%
Effective Continuation Phase Treatment	22.17%	22.92%	0.75%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	53.02%	52.16%	-0.86%
Continuation and Maintenance (C&M) Phase	63.60%	71.55%	7.95%
Follow-Up After Hospitalization for Mental Illness (fuh)			
30-Day Follow-Up	60.11%	58.94%	-1.17%
7-Day Follow-Up	40.43%	36.46%	-3.97%
Follow-Up After Emergency Department Visit for Mental Illness (fum)			

MEASURE/DATA ELEMENT	HEDIS 2017	HEDIS 2018	PERCENTAGE POINT DIFFERENCE
30-Day Follow-Up	55.64%	52.57%	-3.07%
7-Day Follow-Up	39.03%	35.78%	-3.25%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (fua)			
*30-Day Follow-Up: 13-17 Years**	11.43%	5.26%	-6.17%
*7-Day Follow-Up: 13-17 Years**	8.57%	5.26%	-3.31%
30-Day Follow-Up: 18+ Years	10.32%	11.19%	0.87%
7-Day Follow-Up: 18+ Years	7.11%	7.23%	0.12%
30-Day Follow-Up: Total	10.40%	10.94%	0.54%
7-Day Follow-Up: Total	7.22%	7.14%	-0.08%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	76.80%	74.20%	-2.60%
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	69.06%	65.00%	-4.06%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)*	85.00%	86.67%	1.67%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	55.84%	58.35%	2.51%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
*1-5 Years**	NA	NA	NA
6-11 Years	16.10%	22.61%	6.51%
12-17 Years	29.69%	26.67%	-3.02%
Total	24.21%	24.92%	0.71%
Effectiveness of Care: Medication Management			
Annual Monitoring for Patients on Persistent Medications (mpm)			
ACE Inhibitors or ARBs	89.59%	90.36%	0.77%
Diuretics	88.45%	89.53%	1.08%
Total	88.74%	89.99%	1.25%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	2.93%	1.89%	-1.04%
Appropriate Treatment for Children With URI (uri)	86.85%	87.43%	0.58%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	31.25%	32.05%	0.80%
Use of Imaging Studies for Low Back Pain (lbp)	66.48%	66.53%	0.05%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (apc)			
*1-5 Years**	NA	NA	NA

MEASURE/DATA ELEMENT	HEDIS 2017	HEDIS 2018	PERCENTAGE POINT DIFFERENCE
6-11 Years	0.00%	0.00%	0.00%
12-17 Years	0.00%	0.82%	0.82%
Total	0.00%	0.49%	0.49%
Use of Opioids at High Dosage (uod)	NA	44.26	NA
Use of Opioids From Multiple Providers (uop)			
Multiple Prescribers	NA	245.27	NA
Multiple Pharmacies	NA	77.63	NA
Multiple Prescribers and Multiple Pharmacies	NA	46.58	NA
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			
20-44 Years	77.75%	76.43%	-1.32%
45-64 Years	86.38%	86.16%	-0.22%
*65+ Years**	NA	NA	NA
Total	80.24%	79.27%	-0.97%
Children and Adolescents' Access to Primary Care Practitioners (cap)			
12-24 Months	95.52%	95.51%	-0.01%
25 Months - 6 Years	85.32%	84.75%	-0.57%
7-11 Years	88.58%	88.11%	-0.47%
12-19 Years	87.01%	86.74%	-0.27%
Initiation and Engagement of AOD Dependence Treatment (iet)			
*Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years**	NA	NA	NA
*Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years**	NA	NA	NA
*Opioid abuse or dependence: Initiation of AOD Treatment: 13-17 Years**	NA	NA	NA
*Opioid abuse or dependence: Engagement of AOD Treatment: 13-17 Years**	NA	NA	NA
Other drug abuse or dependence: Initiation of AOD Treatment: 13-17 Years	NA	33.55%	NA
Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years	NA	23.23%	NA
Initiation of AOD Treatment: 13-17 Years	32.41%	31.52%	-0.89%
Engagement of AOD Treatment: 13-17 Years	15.17%	21.82%	6.65%
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+ Years	39.84%	44.53%	4.69%
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+ Years	8.83%	7.75%	-1.08%
Opioid abuse or dependence: Initiation of AOD Treatment: 18+ Years	NA	51.12%	NA

MEASURE/DATA ELEMENT	HEDIS 2017	HEDIS 2018	PERCENTAGE POINT DIFFERENCE
Opioid abuse or dependence: Engagement of AOD Treatment: 18+ Years	NA	21.35%	NA
Other drug abuse or dependence: Initiation of AOD Treatment: 18+ Years	NA	43.10%	NA
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years	NA	11.31%	NA
Initiation of AOD Treatment: 18+ Years	NA	43.25%	NA
Engagement of AOD Treatment: 18+ Years	NA	10.90%	NA
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	NA	44.06%	NA
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	NA	7.80%	NA
Opioid abuse or dependence: Initiation of AOD Treatment: Total	NA	51.12%	NA
Opioid abuse or dependence: Engagement of AOD Treatment: Total	NA	21.23%	NA
Other drug abuse or dependence: Initiation of AOD Treatment: Total	NA	41.90%	NA
Other drug abuse or dependence: Engagement of AOD Treatment: Total	NA	12.80%	NA
Initiation of AOD Treatment: Total	39.33%	42.32%	2.99%
Engagement of AOD Treatment: Total	9.26%	11.76%	2.50%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	90.09%	90.51%	0.42%
Postpartum Care	67.69%	66.42%	-1.27%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
*1-5 Years**	NA	NA	NA
6-11 Years	60.34%	54.10%	-6.24%
12-17 Years	56.58%	63.27%	6.69%
Total	58.57%	58.90%	0.33%
Utilization			
Well-Child Visits in the First 15 Months of Life (w15)			
0 Visits	1.92%	1.46%	-0.46%
1 Visit	1.44%	0.24%	-1.20%
2 Visits	2.40%	2.92%	0.52%
3 Visits	6.49%	4.38%	-2.11%
4 Visits	10.34%	9.00%	-1.34%
5 Visits	17.31%	13.63%	-3.68%
6+ Visits	60.10%	68.37%	8.27%

MEASURE/DATA ELEMENT	HEDIS 2017	HEDIS 2018	PERCENTAGE POINT DIFFERENCE
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	59.33%	65.94%	6.61%
Adolescent Well-Care Visits (awc)	52.88%	53.28%	0.40%

** Indicates small denominator; NR: Not Reported; NA: Not Applicable*

The comparison from the previous to the current year revealed a strong increase (>10%) in several rates, including BMI Percentile, Counseling for Nutrition, Counseling for Physical Activity, and Asthma Medication Compliance for 19-50 year-olds. The measure that decreased substantially (>10%) was Persistence of Beta-Blocker Treatment After a Heart Attack. *Table 9: HEDIS Measures with Substantial Change in Rates* highlights the HEDIS measures with substantial increases or decreases in rate from year to year.

Table 9: HEDIS Measures with Substantial Changes in Rates

MEASURE/DATA ELEMENT	HEDIS 2016	HEDIS 2017	Change from 2016 to 2017
Substantial Increase in Rate (>10% improvement)			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	68.75%	79.56%	**10.81%**
Counseling for Nutrition	56.01%	67.40%	**11.39%**
Counseling for Physical Activity	44.71%	63.02%	**18.31%**
BMI Percentile	68.75%	79.56%	**10.81%**
Medication Management for People With Asthma (mma)			
19-50 Years - Medication Compliance 50%	45.60%	56.52%	**10.92%**
Substantial Decrease in Rate (>10% decrease)			
Effectiveness of Care: Cardiovascular Conditions			
Persistence of Beta-Blocker Treatment After a Heart Attack	65.38%	51.35%	**-14.03%**

ATC reported 12 quality clinical withhold measures for 2017. As per the *SCDHHS Medicaid Playbook* and *Managed Care Organizations Policy and Procedure Guide*, individual measures within the quality index are weighted differently. A point value is assigned for each measure based on percentile (<10 Percentile = 1 point; 10-24% = 2 points; 25-49% = 3 points; 50-74% = 4 points; 75-90% = 5 points; >90% = 6 points). Points attained for each

measure are multiplied by individual measure weights then summed to obtain the quality index score. The 2017 rate, percentile, point value, and index score are shown in *Table 10: Quality Withhold Measures*. The Women's Health measure rates generated the highest index score, followed by Diabetes and Pediatric Preventive Care.

Table 10: Quality Withhold Measures

Measure	2017 Rate	2017 Percentile	Point Value	Index Score
DIABETES				
Hemoglobin A1c (HbA1c) Testing	89.23%	90	6	5.15
HbA1c Control (< =9)	49.45%	25	3	
Eye Exam (Retinal) Performed	52.19%	50	4	
Medical Attention for Nephropathy	93.80%	90	6	
WOMEN'S HEALTH				
Timeliness of Prenatal Care	90.51%	90	6	5.40
Breast Cancer Screen	62.88%	90	6	
Cervical Cancer Screen	66.18%	75	5	
Chlamydia Screen in Women (Total)	58.52%	50	4	
PEDIATRIC PREVENTIVE CARE				
6+ Well-Child Visits in First 15 months of Life	68.37%	75	5	4.1
Well Child Visits in 3rd,4th,5th&6th Years of Life	65.94%	25	3	
Adolescent Well-Care Visits	53.28%	50	4	
Weight Assessment/Adolescents: BMI % Total	79.56%	75	5	

Performance Improvement Project Validation

The validation of the performance improvement projects (PIPs) was done in accordance with the protocol developed by CMS titled, *EQR Protocol 3: Validating Performance Improvement Projects Version 2.0, September 2012*. The protocol validates components of the project and its documentation to provide an assessment of the overall study design and methodology of the project. The components assessed are:

- Study topic(s)
- Study question(s)
- Study indicator(s)
- Identified study population
- Sampling methodology (if used)
- Data collection procedures
- Improvement strategies

ATC submitted four projects. They included Improving Dilated Retinal Exam Screening, Post-Partum Care, Member Satisfaction, and Provider Satisfaction. Improving Dilated Retinal Exam Screening and the Member Satisfaction PIPs were retired in August 2018 and therefore not validated. The Post-Partum Care and Provider Satisfaction PIPs were validated. Both projects received a score within the "High Confidence in Reported Results" level and met the validation requirements. *Table 11: Performance Improvement Project Validation Scores* provides an overview of the validation scores.

TABLE 11: Performance Improvement Project Validation Scores

PROJECT	2017 VALIDATION SCORE	2018 VALIDATION SCORE
Improving Dilated Retinal Exam (DRE) Screening	131/131=100% High Confidence in Reported Results	Retired August 2018
Post-Partum Care	Not Validated	98/98=100% High Confidence in Reported Results
Member Satisfaction	120/126=95% High Confidence in Reported Results	Retired August 2018
Provider Satisfaction	Not Validated	87/88=99% High Confidence in Reported Results

CCME identified documentation errors in the Provider Satisfaction PIP and includes the recommendations for correcting these errors in *Table 12: Performance Improvement Project Errors and Recommendations.*

TABLE 12: Performance Improvement Project Errors and Recommendations

Project	Section	Reasoning	Recommendation
Provider Satisfaction	Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result?	Analysis of baseline rate in comparison to goal rate is not provided, and follow-up activities are not documented.	After each measurement period, the narrative should contain a statement about rate in comparison to goal rate; the next steps based on the results should be included in the report.

Details of the validation of the performance measures and performance improvement projects can be found in the *CCME EQR Validation Worksheets, Attachment 3*.

Overall, ATC met 93% of the Standards in the Quality Improvement section. Monitoring provider compliance with wellness care and disease management guidelines was the only standard that received a "Partially Met" score. *Figure 6: Quality Improvement Findings* provides an overview of the scores in 2017 compared to the current review scores.

Figure 6: Quality Improvement Findings

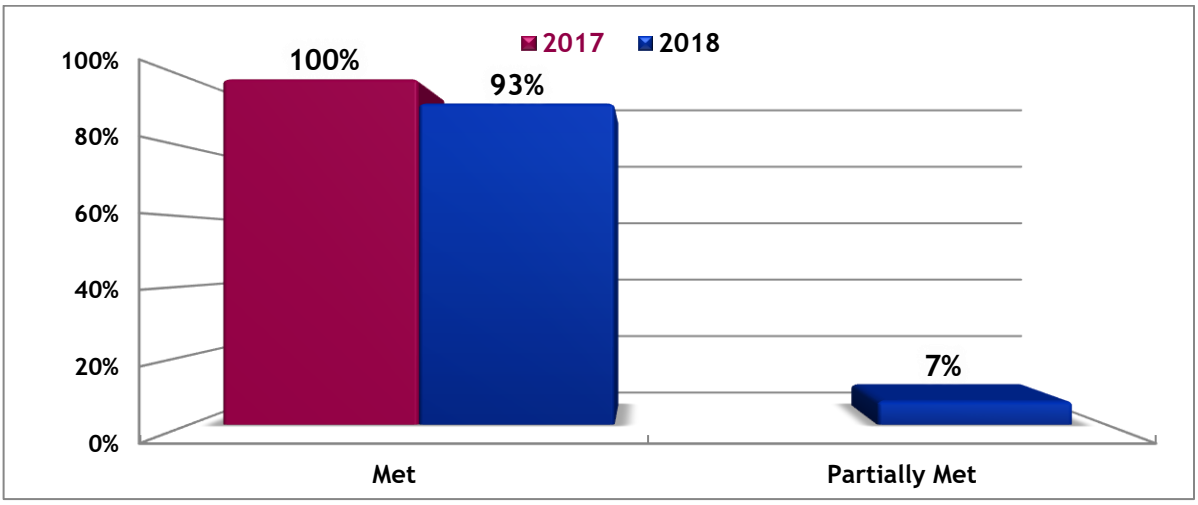


TABLE 13: Quality Management Comparative Data

SECTION	STANDARD	2017 REVIEW	2018 REVIEW
The Quality Improvement (QI) Program	The scope of the QI program includes monitoring of provider compliance with MCO wellness care and disease management guidelines.	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2017 to 2018.

Strengths

- The *2018 Quality Assessment and Performance Improvement Description Medicaid* and the *Quality Assessment and Performance Improvement Program Evaluation – Medicaid 2017* are comprehensive and include all required elements.
- Providers are informed of their QI performance data and feedback regarding ATC's QI activities.
- Only one HEDIS measure had a substantial decline (>10%) from the previous year.

Weaknesses

- The monitoring of provider compliance with the Clinical and Preventive Practice Guidelines does not follow the process outlined in *Policy SC.QI.08, Clinical & Preventive Practice Guidelines*.

Quality Improvement Plan

- Update *Policy SC.QI.08, Clinical & Preventive Practice Guidelines* to better reflect the monitoring process for the clinical and preventive guidelines or ensure the current monitoring process outlined in the policy is followed.

E. Utilization Management

ATC's *Utilization Management Program Description* outlines and defines the Utilization Management (UM) Program for physical and behavioral health. UM policies and procedures define how UM, medical necessity determinations, appeals, and Care Management (CM) services are operationalized to provide services to members. Envolve Pharmacy Solutions, the pharmacy benefit manager, coordinates decisions for drug coverage, and Envolve PeopleCare oversees the behavioral health and substance abuse services. ATC's Senior Medical Director oversees UM activities.

UM approval, denial, and appeal files confirm timely determinations and indicate decisions are aligned with policies. CCME found that *Policy SC22-RX-012, Pharmacy Appeals* reflects incorrect terminology of "adverse coverage determination" and

"redetermination" that is inconsistent with *SCDHHS Contract* terminology. Case management files indicate care gaps are identified and addressed consistently, and services are provided for various risk levels.

Documents, such as the *Utilization Management Program Evaluation* and UMC meeting minutes, indicate ATC monitors and analyzes under- and over-utilization of medical services as required by the contract.

Overall, the UM Program follows requirements described in the *SCDHHS Contract* and the *Code of Federal Regulations*. CCME's review of the UM program reveals ATC's staff use a multi-disciplinary approach to incorporate physical health, behavioral health, and pharmaceutical needs during decision making and when providing service.

As illustrated in Figure 7, 96% of the standards in the UM section are "Met." All standards scored as "Partially Met" and "Not Met" are discussed in detail in the Weaknesses section of this report.

Figure 7: Utilization Management Findings

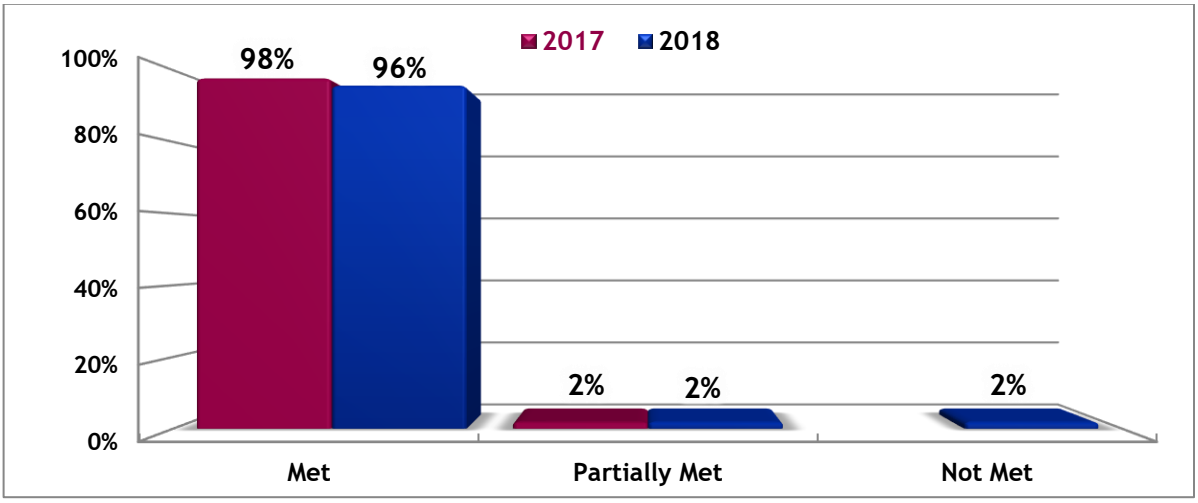


TABLE 14: Utilization Management Comparative Data

SECTION	STANDARD	2017 REVIEW	2018 REVIEW
Utilization Management Program	The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to: timeliness of UM decisions, initial notification, and written (or electronic) verification	Met	Partially Met
Appeals	The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including: the definitions of an adverse benefit determination and an appeal and who may file an appeal	Partially Met	Met
Care Management and Coordination	Care Transitions activities include all contractually required components: the MCO has a designated Transition Coordinator who meets contract requirements	Met	Not Met

The standards reflected in the table are only the standards that showed a change in score from 2017 to 2018.

Strengths

- Requests for more information are clearly documented before denials are issued.
- Staff from the Sickle Cell CM program hand-deliver cases of water to members who are case-managed; this was discussed during the onsite visit.

Weaknesses

- *Policy SC.UM.05, Timeliness of UM Decisions and Notifications*, the *Provider Manual*, the *Member Handbook*, and the *UM Program Description* incorrectly indicate ATC may extend expedited service authorizations for an additional 48 hours when requested by the member, provider, or the member's authorized representative.
- Drug changes in the Preferred Drug List (PDL) Updates do not note consistently what the previous drug requirements are or what the current changes are (e.g. Q3 2018 Sumatriptan succinate quantity limit changed from 2.0ml per 30 days to 2.5ml per 30 days).

- Q3 Pharmacy and Therapeutics (P&T) Committee meeting minutes (page 7) do not capture all of the drugs in the *Q3 PDL Updates* identified as REMOVE, and Q4 P&T Committee Minutes (page 8) says, "There are no PDL changes for this quarter" when the respective *PDL Updates* had three drugs noted as "CHANGE," and the PA was removed.
- *Policy SC.UM.13, Member Appeals* does not indicate behavioral health (BH) and pharmacy appeals are included.
- *Policy, CC.PHAR.08, Pharmacy Prior Authorization and Medical Necessity Criteria* incorrectly references the terms "adverse determination" (page 2) and "adverse coverage determination" (page 3).
- *Policy SC.UM.13, Member Appeals*, the *Provider Manual*, the *Member Handbook*, and the member website, indicate ATC has14 calendar days to receive a written request confirming an oral appeal. However, the provider website incorrectly references 30 calendar days for receiving written confirmation requests for an oral appeal.

  Additionally, the timeframe from when the calendar days begin for receiving written confirmation requests is not clearly described in member and provider website sections, the *Provider Manual*, and *Member Handbook*.
- *Policy SC.UM.13, Member Appeals* notes the following different start times for when the appeal resolution timeline begins:
  - Page 4 states "The timeline for the appeal begins with Absolute Total Care's receipt of the member's initial notification of appeal (oral or written)."
  - Pages 2, 4, and 6 state, "The appeal timeline will begin when the signed member's consent is received."
- Targeted Case Management referrals for alcohol and substance abuse individuals, children in foster care, and children in the juvenile justice system are not included in the *CM Program Description* (page 18).
- *Policy SC.UM.41.01, Transition of Care* and *Policy CC.UM.20, Continuity and Coordination of Services Care Transitions* do not contain the requirement from *SCDHHS Contract, Section 5.6.6.5* regarding members with appeals in process.
- A designated Transition Coordinator is not identified by the health plan as required.

Quality Improvement Plan

- Revise the *Provider Manual* (page 7), *Member Handbook* (page 27), *Program Description* (page 20) and *Policy SC.UM.05, Timeliness of UM Decisions and Notifications* (page 3) to indicate expedited service authorizations can be extended up to 14 calendar days, if requested by the member.

- Designate a person with appropriate training and experience as the Transition Coordinator, as required in *SCDHHS Contract, Section 5.6.2*.

Recommendations

- When communicating drug changes in the PDL Updates, indicate both the previous requirement and changes to the current requirement.
- Ensure respective P&T Committee minutes and PDL Updates have consistent documentation.
- Edit *Policy SC.UM.13, Member Appeals* to indicate it applies to BH and pharmacy appeals.
- Edit *Policy CC.PHAR.08, Pharmacy Prior Authorization and Medical Necessity Criteria* to use current *SCDHHS Contract* terminology of "adverse benefit determination" instead of "adverse coverage determination" and "adverse determination."
- Edit the provider website to references 14 calendar days for receiving written confirmation requests for oral appeals and to be consistent with *Policy SC.UM.13, Member Appeals*, the *Provider Manual*, the *Member Handbook*, and the member website.

  Additionally, clearly indicate the timeframe from when the calendar days begin, for receiving written confirmation requests, in the *Provider Manual*, *Member Handbook*, and the member and provider website sections.
- Edit *Policy SC.UM.13, Member Appeals* to clarify when the appeal resolution timeline begins and to clearly indicate circumstances when appeal start times may differ.
- Edit the *CM Program Description* to include Targeted Case Management referrals for alcohol and substance abuse individuals, children in foster care, and children in the juvenile justice system.
- Edit *Policy SC.UM.41.01, Transition of Care* or *Policy CC.UM.20, Continuity and Coordination of Services Care Transitions* to include *SCDHHS Contract, Section 5.6.6.5* requirements regarding members with appeals in process. Additionally, cross reference the policies to assist staff in obtaining complete transition of care requirements contained in both documents.

F. Delegation

Policy CC.COMP.21, Third Party Oversight Program Description describes the Centene Third Party Oversight Program (TPOP) for national vendors. The TPOP has several components that promote communication, collaboration, and ensure third party adherence to state, federal and NCQA requirements, as applicable. The oversight and monitoring of third parties involves coordinated activities between the Corporate

Compliance Performance Office, National Contracting, Procurement, business owners, Corporate, the Entities, and third parties. ATC ensures written agreements with all third parties performing delegated functions.

ATC's delegated entities and services are displayed in *Table 15: Delegated Entities and Services*.

Table 15: Delegated Entities and Services

Delegated Entities	Delegated Services
Envolve PeopleCare	Behavioral Health - Utilization Management (UM)
National Imaging Associates (NIA)	Radiology - UM; Credentialing/Recredentialing; Network Development & Maintenance
Envolve PeopleCare (Legacy Nutur & NurseWise)	Disease Management and Nurse Hotline
Envolve Vision	Vision - Claims Adjudication; Credentialing/ Recredentialing; Network Development & Maintenance
Envolve Pharmacy	Pharmacy Benefit Management - UM; Claims Adjudication; Network Development & Maintenance
CVS Minute Clinic, AU Medical Center/Medical College of Georgia (MCG/PPG), Greenville Health Systems, Health Network Solutions (HNS), Management Network Services, Mary Black Network, MUSC – Medical University of South Carolina, Preferred Care of Aiken, St. Francis Physician Services, Inc., Palmetto USC/ University of South Carolina Medical Group, AnMed Health, and Roper St Francis	Credentialing/Recredentialing

Envolve PeopleCare is a wholly-owned subsidiary of Centene Corporation, and ATC staff report that even though oversight will be conducted, they may not be considered delegated functions in the future. CCME confirmed during the onsite discussion that some of the behavioral health related services conducted by Envolve PeopleCare transitioned back to the health plans in 2018.

Policy CC.CRED.12, Oversight of Delegation Credentialing addresses credentialing delegation and *Attachment J* of the policy addresses ATC's unique delegated credentialing requirements. *Attachment J* does not include the Suspended List and the Behavioral Health Actions List as queries required by SCDHHS Program Integrity. CCME

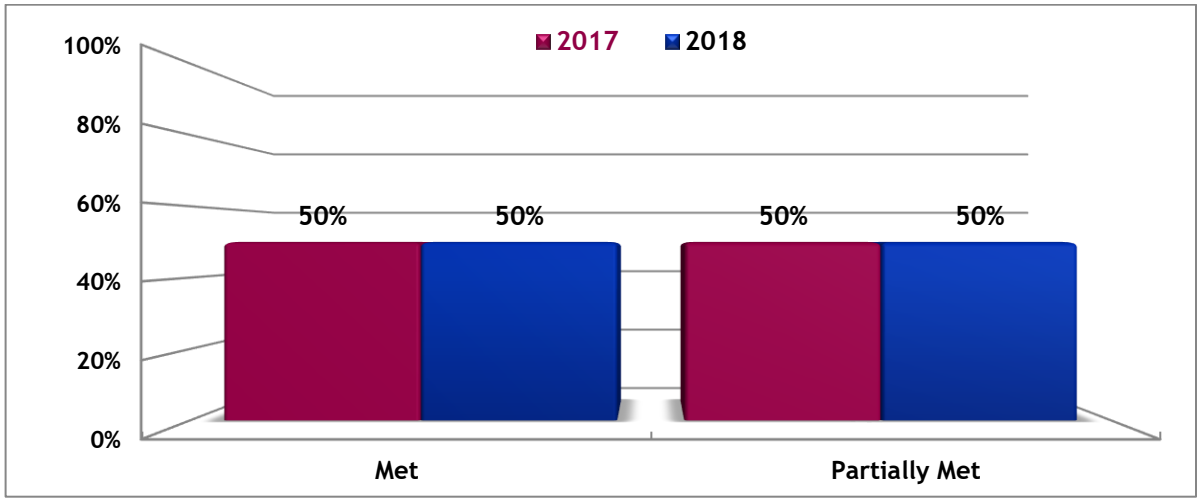
recommends adding a statement to *Attachment J* that annual audits are required regardless of the delegated entity's accreditation status.

Exhibit B Health Plan Unique Requirements Grid 2017/2018 does not include the Suspended List and the Behavioral Health Actions List as required queries. In addition, *Exhibit B* health plan specific elements do not match the health plan specific elements listed in the tool used for delegation oversight. ATC needs to update *Exhibit B* to reflect the current oversight tool.

CCME received evidence of annual oversight review for all delegated entities. A few concerns are noted for the credentialing delegation oversight; they are addressed in the Weaknesses section.

As noted in *Figure 8: Delegation Findings*, one standard in the Delegation section received a "Partially Met" score.

Figure 8: Delegation Findings



Weaknesses

- *Policy CC.CRED.12* states if the delegate is NCQA Certified or Accredited, the plan may omit the annual audit; however, the *SCDHHS Contract, Section 2.5.8* includes the requirement to monitor the subcontractor's performance on an ongoing basis, to include annual review.
- *Policy CC.CRED.12, Oversight of Delegation Credentialing, Attachment J* and *Exhibit B* did not include the Suspended List and the Behavioral Health Actions List as queries required by SCDHHS Program Integrity.

- *Policy CC.CRED.12, Exhibit B Health Plan Unique Requirements Grid 2017/2018* specific elements did not match the health plan specific elements listed in the current tool used for delegation oversight.
- Review of credentialing delegation oversight reflects the following concerns:
  - In some cases, the annual oversight letter indicates a score of 100%, yet corrective action items are documented. ATC indicated during onsite discussion that this information is misleading and as a result they had changed their scoring tool.
  - There does not appear to be a clear process for following up on deficiencies found in the annual oversight audit. This is evidenced by letters that do not mention whether a CAP is required or a date by which the CAP items need to be addressed. The letter simply gives the score (i.e. 82%) and indicates the items will be reviewed for compliance during the next annual audit.
  - Some SCDHHS Program Integrity required queries were not evaluated in the annual oversight file review.

Quality Improvement Plans

- Add a statement to *Policy CC.CRED.12, Attachment J* that annual audits are required regardless of the delegated entity's accreditation status.
- Update *Attachment J* and *Exhibit B* for *Policy CC.CRED.12* to reflect all queries required by SCDHHS Program Integrity and ensure the queries are addressed in the file review oversight.
- Ensure *Policy CC.CRED.12, Exhibit B* health plan specific elements match the current oversight tool.
- Implement a corrective action plan follow-up process to ensure deficiencies identified during the delegated entity oversight audits are corrected by a specified date.

Recommendations

- Ensure delegation oversight letters do not reflect a score of 100% when deficiencies are identified in the review.

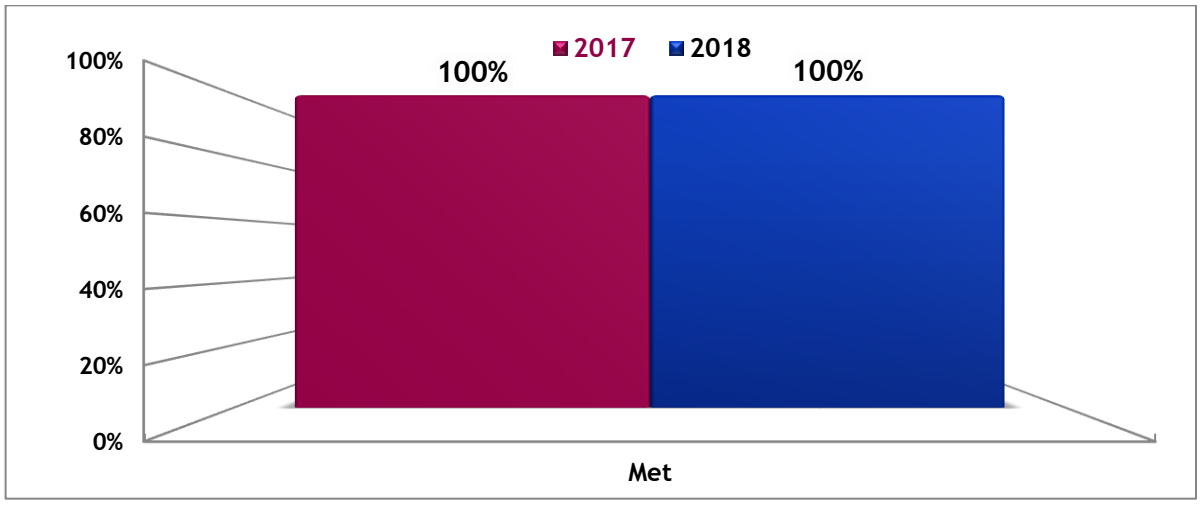
G. State Mandated Services

ATC ensures Early and Periodic Screening Diagnostic and Treatment (EPSDT) services for members through the month of their 21st birthday and has several processes in place to notify and remind providers of needed EPSDT services. These tools include the *EPSDT Tool Kit*, the *Provider Manual*, and sending monthly membership lists of missed or upcoming services. The plan monitors provider compliance with provision of EPSDT services and required immunizations through medical record reviews conducted by the

ATC Quality Improvement Department. ATC provides all core benefits specified by the *SCDHHS Contract*.

As noted in *Figure 9: State Mandated Services*, ATC receives a score of "Met" for 100% of the standards in the State Mandated Services section.

Figure 9: State Mandated Services



ATTACHMENTS

- Attachment 1: Initial Notice, Materials Requested for Desk Review
- Attachment 2: Materials Requested for Onsite Review
- Attachment 3: EQR Validation Worksheets
- Attachment 4: Tabular Spreadsheet

A. Attachment 1: Initial Notice, Materials Requested for Desk Review

December 03, 2018

Mr. John McClellan
President
Absolute Total Care
1441 Main Street, Suite 900
Columbia, SC 29201

Dear Mr. McClellan:

At the request of the South Carolina Department of Health and Human Services (SCDHHS) this letter serves as notification that the 2018 External Quality Review (EQR) of Absolute Total Care is being initiated. An external quality review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) is required by your contract with SCDHHS in relation to your organization's administration of a managed care program for the Healthy Connections Medicaid recipients.

The methodology used by CCME to conduct this review will follow the protocols developed by the Centers for Medicare and Medicaid Services (CMS) for external quality review of Medicaid Managed Care Organizations. As required by these protocols, the review will include both a desk review (at CCME), onsite visit and will address all contractually required services as well as follow up of any areas of weakness identified during the previous review. The CCME EQR team plans to conduct the onsite visit on **February 28th and March 1st.**

In preparation for the desk review, the items on the enclosed desk materials list should be provided to CCME no later than **December 17, 2018.**

To help with submission of the desk materials, we have set-up a secure file transfer site to allow health plans under review to submit desk materials directly to CCME thru the site. The file transfer site can be found at:

https://eqro.thecarolinascenter.org

I have included written instructions on how to use the file transfer site and would be happy to answer any questions on how to utilize the file transfer site if needed. An opportunity for a conference call with your staff, to describe the review process and answer any questions prior to the onsite visit, is being offered as well. Please contact me directly at 803-212-7582 if you would like to schedule time for either of these conversational opportunities.

Thank you and we look forward to working with you.

Sincerely,

Sandi Owens

Sandi Owens, LPN
Manager, External Quality Review

Enclosure
cc: SCDHHS

External Quality Review 2018

MATERIALS REQUESTED FOR DESK REVIEW

1. Copies of all current policies and procedures, as well as a complete index which includes policy name, number and department owner. The date of the addition/review/revision should be identifiable on each policy.

2. Organizational chart of all staff members including names of individuals in each position, and any current vacancies.

3. Current membership demographics including total enrollment and distribution by age ranges, sex, and county of residence.

4. Documentation of all service planning and provider network planning activities (e.g., copies of complete geographic assessments, provider network assessments, enrollee demographic studies, and population needs assessments) that support the adequacy of the provider base. Please include the maximum allowed and the current member-to-PCP ratios and member-to-specialist ratios.

5. A complete list of network providers for the Healthy Connections Choices (HCC) members. The list should be submitted as an excel spreadsheet in the format listed in the table below. Specialty codes and county codes may be used however please provide an explanation of the codes used by your organization.

Excel Spreadsheet Format

List of Network Providers for Healthy Connections Choices Members	
Practitioner's First Name	Practitioner's Last Name
Practitioner's title (MD, NP, PA, etc.)	Phone Number
Specialty	Counties Served
Practice Name	Indicate Y/N if provider is accepting new patients
Practice Address	Age Restrictions

6. The total number of unique specialty providers as well as the total number of unique primary care providers currently in the network.

7. A current provider list/directory as supplied to members.

8. A copy of the current Compliance plan and organization chart for the compliance department. Include the Fraud, Waste, and Abuse plan if a separate document has been developed, as well as any policies/procedures related to provider payment suspensions and recoupments of overpayments, and the pharmacy lock-in program.

9. A description of the Credentialing, Quality Improvement, Medical/Utilization Management, Disease/Case Management, and Pharmacy Programs.

10. The Quality Improvement work plans for 2017 and 2018.

11. The most recent reports summarizing the effectiveness of the Quality Improvement, Medical/Utilization Management, and Disease/Case Management Programs.

12. Documentation of all Performance Improvement Projects (PIPs) completed or planned since the previous Annual Review, and any interim information available for those projects currently in progress. This documentation should include information from the project that explains and documents all aspects of the project cycle (i.e. analytic plans, reasons for choosing the topic, measurement definitions, interventions planned or implemented, calculated results, analysis of results for each measurement period, barriers to improvement and interventions to address each barrier, statistical analysis (if sampling was used), etc.

13. Minutes of all committee meetings in the past year reviewing or taking action on SC Medicaid-related activities. All relevant attachments (e.g., reports presented, materials reviewed) should be included. If attachments are provided as part of another portion of this request, a cross-reference is satisfactory, rather than sending duplicate materials.

14. Membership lists and a committee matrix for all committees including the professional specialty of any non-staff members. Please indicate which members are voting members and include the committee charters if available.

15. Any data collected for the purposes of monitoring the utilization (over and under) of health care services.

16. Copies of the most recent physician profiling activities conducted to measure contracted provider performance.

17. Results of the most recent medical office site reviews, medical record reviews and a copy of the tools used to complete these reviews.

18. A complete list of all members enrolled in the case management program from December 2017 through November 2018. Please include open and closed case management files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for case management.

19. A copy of staff handbooks/training manuals, orientation and educational materials and scripts used by Member Services Representatives and/or Call Center personnel.

20. A copy of the member handbook and any statement of the member bill of rights and responsibilities if not included in the handbook.

21. A report of findings from the most recent member and provider satisfaction survey, a copy of the tool and methodology used. If the survey was performed by a subcontractor, please include a copy of the contract, final report provided by the subcontractor, and other documentation of the requested scope of work.

22. A copy of any member and provider newsletters, educational materials and/or other mailings. Include new provider orientation and ongoing provider education materials.

23. A copy of the Grievance, Complaint and Appeal logs for the months of December 2017 through November 2018.

24. Copies of all letter templates for documenting approvals, denials, appeals, grievances and acknowledgements.

25. Service availability and accessibility standards and expectations, and reports of any assessments made of provider and/or internal MCO compliance with these standards.

26. Preventive health practice guidelines recommended by the MCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated and how consistency with other MCO services and covered benefits is assessed.

27. Clinical practice guidelines for disease and chronic illness management recommended by the MCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated and how consistency with other MCO services and covered benefits is assessed.

28. A list of physicians currently available for utilization consultation/review and their specialty.

29. A copy of the provider handbook or manual.

30. A sample provider contract.

31. Documentation supporting requirements included in the Information Systems Capabilities Assessment for Managed Care Organizations (ISCAs). Please provide the following:
    a. A completed ISCA. *(Not a summarized ISCA or a document that contains ISCA-like information, but the ISCA itself.)*
    b. A network diagram showing (at a minimum) the relevant components in the information gathering, storage, and analysis processes. *(We are interested in the processing of claims and data in South Carolina, so if the health plan in South Carolina is part of a larger organization, the emphasis or focus should be on the network resources that are used in handling South Carolina data.)*
    c. A flow diagram or textual description of how data moves through the system. *(Please see the comment on b. above.)*
    d. A copy of the IT Disaster Recovery Plan or Business Continuity Plan.
    e. A copy of the most recent disaster recovery or business continuity plan test results.
    f. An organizational chart for the IT/IS department and a corporate organizational chart that shows the location of the IT organization within the corporation.
    g. A copy of the most recent data security audit, if completed.
    h. A copy of the policies or program description that address the information systems security and access management. Please also include polices with respect to email and PHI.
    i. A copy of the Information Security Plan & Security Risk Assessment.

32. A listing of all delegated activities, the name of the subcontractor(s), methods for oversight of the delegated activities by the MCO, and any reports of activities submitted by the subcontractor to the MCO.

33. Sample contract used for delegated entities. Include a sample contract for each type of service delegated; i.e. credentialing, behavioral health, utilization management, external review, case/disease management, etc. Specific written agreements with subcontractors may be requested at the onsite review at CCME's discretion.

34. Results of the most recent monitoring activities for all delegated activities. Include a full description of the procedure and/or methodology used and a copy of any tools used.

35. All HEDIS data and other performance and quality measures collected or planned. Required data and information include the following:
    a. final HEDIS audit report
    b. data collection methodology used (e.g., administrative data, including sources; medical record review, including how records were identified and how the sample was chosen; hybrid methodology, including data sources and how the sample was chosen; or survey, including a copy of the tool, how the sample was chosen and how the data was input), including a full description of the procedures;

c. reporting frequency and format;
d. specifications for all components used to identify the eligible population (e.g., member ID, age, sex, continuous enrollment calculation, clinical ICD/CPT codes, member months/years calculation, other specified parameters);
e. programming specifications that include data sources such as files/databases and fields with definitions, programming logic and computer source codes;
f. denominator calculations methodology, including:
    1) data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
    2) specifications for all components used to identify the population for the denominator;
g. numerator calculations methodology, including:
    1) data sources used to calculate the numerator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
    2) specifications for all components used to identify the population for the numerator;
h. calculated and reported rates.

36. Provide electronic copies of the following files:
    a. Credentialing files (including signed Ownership Disclosure Forms) for:
        i. Ten PCP's (Include two NP's acting as PCP's, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers;
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    b. Recredentialing (including signed Ownership Disclosure Forms) files for:
        i. Ten PCP's (Include two NP's acting as PCP's, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    c. Twenty medical necessity denial files (acute inpatient, outpatient and behavioral health) made in the months of December 2017 through November 2018. Include any medical information and physician review documentations used in making the denial determination.
    d. Twenty-five utilization approval files (acute inpatient, outpatient and behavioral health) made in the months of December 2017 through November 2018, including any medical information and approval criteria used in the decision. Please include prior authorizations for surgery and/or hospital admissions, concurrent stay, and retrospective review of admissions and of emergency care.

Note: Appeals, Grievances, and Care Coordination/Case Management files will be selected from the logs received with the desk materials. A request will then be sent to the plan to send electronic copies of the files to CCME.

These materials:

- **should be organized and uploaded to the secure CCME EQR File Transfer site at:** https://eqro.thecarolinascenter.org

B. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2018

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were submitted.
2. The attachment to Policy CC.COMP.36 titled “OIG Compliance Now Database Source List”.
3. The pharmacy lock-in letter template.
4. The clinical practice guidelines compliance report for Envolve PeopleCare (BH providers).
5. Copy of policy CP.MP.68 – Medical Necessity Criteria.
6. Copy of policy UM.02.05- Interrater Reliability.
7. A policy addressing Member Service Call Center performance requirements (call metrics such as average speed of answer, abandonment rate, etc.).
8. The most recent report of call center performance statistics.
9. Policy SC.QI.04, Evaluation of Practitioners Availability.
10. Delegation: Envolve Pharmacy 2018 Annual Audit Executive Summary and National Imaging Associates 2018 Annual Audit Executive Summary.
11. Several credentialing and/or recredentialing files were missing information or need explanation. See attached list.

C. Attachment 3: EQR Validation Worksheets

CCME EQR PIP Validation Worksheet

Plan Name:	**ABSOLUTE TOTAL CARE**
Name of PIP:	**PROVIDER SATISFACTION (NON-CLINICAL)**
Reporting Year:	**2018**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	ATC provider rating of health plan was below the target rate.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This PIP addressed enrollee care and services.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	All targeted populations were included.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Research question was stated clearly in PIP report.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Indicator was clearly defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measured changes in provider satisfaction.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	Enrollees were defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	Data captured the relevant population sector.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**MET**	The study used the NCQA protocol for sampling.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**MET**	The study used the NCQA protocol for sampling.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**MET**	The study used the NCQA protocol for sampling.

Component / Standard (Total Points)	Score	Comments
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data were documented.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Design was systematic in collecting valid and reliable data.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments for data collection were adequate and valid.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	The Data Analysis Plan was documented.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	A qualified vendor collected the data.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**NA**	Interventions are not reported.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analyses were performed according to the Data Analysis Plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	The rate was presented clearly.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**NA**	Baseline data only are presented. Documentation regarding factors for comparability and validity were noted.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**NOT MET**	Analysis of baseline rate in comparison to goal rate is not provided, and follow-up activities are not documented. ***Recommendation: After each measurement period, the narrative should contain a statement on rate in comparison to goal rate, as well, the next steps based on the results should be included in the report.***
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**NA**	Baseline data only.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	Baseline data only.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Baseline data only.

Component / Standard (Total Points)	Score	Comments
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Baseline data only.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Baseline data only.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	5	5
5.2	10	10
5.3	5	5
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

Steps	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	NA	NA
Step 8		
8.1	5	5
8.2	10	10
8.3	NA	NA
8.4	1	0
Step 9		
9.1	NA	NA
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA
Step 10		
10.1	NA	NA
Verify	NA	NA

Project Score	**87**
Project Possible Score	**88**
Validation Findings	**99%**

AUDIT DESIGNATION
HIGH CONFIDENCE

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR PIP Validation Worksheet

Plan Name:	**ABSOLUTE TOTAL CARE**
Name of PIP:	**POST PARTUM**
Reporting Year:	**2018**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	The Health Plan's 2018 HEDIS hybrid rate for postpartum care was 66.42% which was below the 2017 NCQA Quality Compass 75th percentile.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	PIP addresses a key aspect of enrollee care.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIP included relevant population.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Research question was stated clearly in PIP report.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	The indicator was a HEDIS measure.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	The indicator measured changes in health status.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	Enrollees were defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	Data captured the relevant population sector.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**MET**	The study used HEDIS guidelines for sampling. Margin of error was reported.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**MET**	The study used HEDIS guidelines for sampling.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**MET**	The study used HEDIS guidelines for sampling.

Component / Standard (Total Points)	Score	Comments
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data were documented.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Design was systematic in collecting valid and reliable data.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments for data collection were adequate.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data Analysis Plan was documented.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	The study documents qualified staff collected the data.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions to address barriers were documented.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analyses were performed according to the Data Analysis Plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	PIP results were presented clearly and accurately.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**NA**	Baseline data only.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Interpretation of the findings was provided.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**NA**	Baseline data only.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	Unable to judge; baseline data only.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Unable to judge; baseline data only.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Unable to judge; baseline data only.

Component / Standard (Total Points)	Score	Comments
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Baseline data only.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	Not Applicable.

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	5	5
5.2	10	10
5.3	5	5
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

Steps	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	5	5
8.2	10	10
8.3	NA	NA
8.4	1	1
Step 9		
9.1	NA	NA
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA
Step 10		
10.1	NA	NA
Verify	NA	NA

Project Score	98
Project Possible Score	98
Validation Findings	100%

AUDIT DESIGNATION
HIGH CONFIDENCE

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR PM Validation Worksheet

Plan Name:	**Absolute Total Care**
Name of PM:	**HEDIS**
Reporting Year:	**MY 2017**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS Technical Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Documentation is appropriate.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Data sources for denominator are complete and accurate.
D2. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of denominator is accurate.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	Data sources for numerator are complete and accurate.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of numerator is accurate.
N3. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**MET**	Abstraction methods are accurate.
N4. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**MET**	Hybrid methods are accurate.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**MET**	Numerator for rates is accurate.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling	Sample was unbiased.	**MET**	Sample was unbiased.
S2. Sampling	Sample treated all measures independently.	**MET**	Sampling was appropriate.
S3. Sampling	Sample size and replacement methodologies met specifications.	**MET**	Sample methods met specifications.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	**MET**	Measures were reported accurately.
R2. Reporting	Was the measure reported according to specifications?	**MET**	Measures were reported according to specifications (HEDIS).

VALIDATION SUMMARY			
Element	**Standard Weight**	**Validation Result**	**Score**
G1	10	MET	10
D1	10	MET	10
D2	5	MET	5
N1	10	MET	10
N2	5	MET	5
N3	5	MET	5
N4	5	MET	5
N5	5	MET	5
S1	5	MET	5
S2	5	MET	5
S3	5	MET	5
R1	10	MET	10
R2	5	MET	5

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**85**
Measure Weight Score	**85**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR Survey Validation Worksheet

Plan Name	**ABSOLUTE TOTAL CARE**
Survey Validated	**CAHPS MEDICAID ADULT 5.0H**
Validation Period	2018

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted, since the lack of information is relevant to the assessment of that activity. (V2 updated based on September 2012 version of EQR protocol 5)

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND INTENDED USE

Survey Element		Element Met / Not Met	Comments And Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	The statement of purpose is documented. Documentation: *Morpace 2018 CAHPS® Adult Medicaid Survey Summary Report*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	The study objectives are clearly documented. Documentation: *Morpace 2018 CAHPS® Adult Medicaid Survey Summary Report*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Intended audience is identified and documented. Documentation: *Morpace 2018 CAHPS® Adult Medicaid Survey Summary Report*

ACTIVITY 2: ASSESS THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	Reliability of the survey is documented. Documentation: *Morpace 2018 CAHPS® Adult Medicaid Survey Summary Report*
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	Validity of the survey and responses are documented. Documentation: *Morpace 2018 CAHPS® Adult Medicaid Survey Summary Report*

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments And Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Definition of the study population was clearly defined. Documentation: *Morpace 2018 CAHPS® Adult Medicaid Survey Summary Report*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Specifications for sample frame were clearly defined. Documentation: *Morpace 2018 CAHPS® Adult Medicaid Survey Summary Report*
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	The sampling strategy was appropriate. Documentation: *Morpace 2018 CAHPS® Adult Medicaid Survey Summary Report*
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**MET**	The required sample size is 1,350 according to NCQA. ATC had a sample size of 1,823. Documentation: *Morpace 2018 CAHPS® Adult Medicaid Survey Summary Report*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Appropriate procedures were used to select the sample. Documentation: *Morpace 2018 CAHPS® Adult Medicaid Survey Summary Report*

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments And Documentation
4.1	Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	Specifications for calculating raw and adjusted response rates were aligned with NCQA protocol and are clear and appropriate. Documentation: *Morpace 2018 CAHPS® Adult Medicaid Survey Summary Report*
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**MET**	Response rate was evaluated, and implications of response rate noted. Documentation: *Morpace 2018 CAHPS® Adult Medicaid Survey Summary Report* *December 2018 QIC Minutes*

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	A Quality Assurance Plan was in place. Documentation: *Morpace 2018 CAHPS® Adult Medicaid Survey Summary Report*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the planned approach. Documentation: *Morpace 2018 CAHPS® Adult Medicaid Survey Summary Report*
5.3	Were confidentiality procedures followed?	**MET**	Confidentiality procedures were followed. Documentation: *Morpace 2018 CAHPS® Adult Medicaid Survey Summary Report*

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	**MET**	Data were analyzed. Documentation: *Morpace 2018 CAHPS® Adult Medicaid Survey Summary Report*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests were conducted. Documentation: *Morpace 2018 CAHPS® Adult Medicaid Survey Summary Report*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Survey conclusions were supported by findings. Documentation: *Morpace 2018 CAHPS® Adult Medicaid Survey Summary Report*

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	•The use of a CAHPS certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys. •Morpace, as a vendor, provides a full report of process and results that meets the necessary requirements and expectations of a survey report.
7.2	Identify the technical weaknesses of the survey and its documentation.	No technical weaknesses were noted in the review.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The overall response rate was 19% (n=348 valid surveys). The target response rate according to NCQA is 40.0%. The target number of valid surveys (n=411) was not met, nor was the NCQA target response rate. The response rate was below the 2017 NCQA National average response rate (23%).
7.4	What conclusions are drawn from the survey data?	Key focus topics are Getting Care as Soon as Needed (Getting Care Quickly Composite), Treated with Courtesy and Respect (Customer Service Composite), and Got information or Help Needed (Customer Care Composite) Documentation: *QIC 2018 Minutes*
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	Assessment of access, quality, and timeliness is encompassed in the results of CAHPS survey. Documentation: *Morpace 2018 CAHPS® Adult Medicaid Survey Summary Report*
7.6	Comparative information about all MCOs (as appropriate).	Comparative information was provided and documented. Documentation: *Morpace 2018 CAHPS® Adult Medicaid Survey Summary Report*

CCME EQR Survey Validation Worksheet

Plan Name	**ABSOLUTE TOTAL CARE**
Survey Validated	**CAHPS MEDICAID CHILD 5.0H**
Validation Period	2018

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted, since the lack of information is relevant to the assessment of that activity. (V2 updated based on September 2012 version of EQR protocol 5)

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND INTENDED USE

Survey Element		Element Met / Not Met	Comments And Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	The statement of purpose is documented. Documentation: *Morpace 2018 CAHPS® Child Medicaid Survey Summary Report*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	The study objectives are documented clearly. Documentation: *Morpace 2018 CAHPS® Child Medicaid Survey Summary Report*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Intended audience is identified and documented. Documentation: *Morpace 2018 CAHPS® Child Medicaid Survey Summary Report*

ACTIVITY 2: ASSESS THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	Reliability of the survey is documented. Documentation: *Morpace 2018 CAHPS® Child Medicaid Survey Summary Report*
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	Validity of the survey and responses are documented. Documentation: *Morpace 2018 CAHPS® Child Medicaid Survey Summary Report*

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments And Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Definition of the study population defined clearly. Documentation: *Morpace 2018 CAHPS® Child Medicaid Survey Summary Report*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Specifications for sample frame were clearly defined. Documentation: *Morpace 2018 CAHPS® Child Medicaid Survey Summary Report*
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	The sampling strategy was appropriate. Documentation: *Morpace 2018 CAHPS® Child Medicaid Survey Summary Report*
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**MET**	The required sample size is 1,350 according to NCQA. ATC had a sample size of 2,558. Documentation: *Morpace 2018 CAHPS® Child Medicaid Survey Summary Report*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Appropriate procedures were used to select the sample. Documentation: *Morpace 2018 CAHPS® Child Medicaid Survey Summary Report*

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments And Documentation
4.1	Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	Specifications for calculating raw and adjusted response rates were aligned with NCQA protocol, and are clear and appropriate. Documentation: *Morpace 2018 CAHPS® Child Medicaid Survey Summary Report*
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**MET**	Response rate was evaluated, and implications of response rate are noted. Documentation: *Morpace 2018 CAHPS® Child Medicaid Survey Summary Report* *December 2018 QIC Minutes*

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	A Quality Assurance Plan was in place. Documentation: *Morpace 2018 CAHPS® Child Medicaid Survey Summary Report*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the planned approach. Documentation: *Morpace 2018 CAHPS® Child Medicaid Survey Summary Report*
5.3	Were confidentiality procedures followed?	**MET**	Confidentiality procedures were followed. Documentation: *Morpace 2018 CAHPS® Child Medicaid Survey Summary Report*

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	**MET**	Data were analyzed. Documentation: *Morpace 2018 CAHPS® Child Medicaid Survey Summary Report*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests were conducted. Documentation: *Morpace 2018 CAHPS® Child Medicaid Survey Summary Report*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Survey conclusions were supported by findings. Documentation: *Morpace 2018 CAHPS® Child Medicaid Survey Summary Report*

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	•The use of a CAHPS certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys. •Morpace, as a vendor, provides a full report of process and results that meet the necessary requirements and expectations of a survey report.
7.2	Identify the technical weaknesses of the survey and its documentation.	No technical weaknesses were noted in the review.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The overall response rate was 22% (n=559 valid surveys). The target response rate according to NCQA is 40.0%. The target number of valid surveys (n=411) was met, but the NCQA target response rate was not met. The response rate was the same as the 2017 NCQA National average response rate (22%).
7.4	What conclusions are drawn from the survey data?	For Child CAHPS, key topics are Care Coordination (Care Coordination Composite) and Listen Carefully to You (How Well Doctors Communicate). Documentation: *QIC 2018 Minutes*
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	Assessment of access, quality, and timeliness is encompassed in the results of CAHPS survey. Documentation: *Morpace 2018 CAHPS® Child Medicaid Survey Summary Report*
7.6	Comparative information about all MCOs (as appropriate).	Comparative information was provided and documented. Documentation: *Morpace 2018 CAHPS® Child Medicaid Survey Summary Report*

CCME EQR Survey Validation Worksheet

Plan Name	**ABSOLUTE TOTAL CARE**
Survey Validated	**CAHPS MEDICAID CHILD CCC 5.0H**
Validation Period	2018

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted, since the lack of information is relevant to the assessment of that activity. (V2 updated based on September 2012 version of EQR protocol 5)

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND INTENDED USE

Survey Element		Element Met / Not Met	Comments And Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	The statement of purpose is documented. Documentation: *Morpace 2018 CAHPS® Child CCC Medicaid Survey Summary Report*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	The study objectives are documented clearly. Documentation: *Morpace 2018 CAHPS® Child CCC Medicaid Survey Summary Report*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Intended audience is identified and documented. Documentation: *Morpace 2018 CAHPS® Child CCC Medicaid Survey Summary Report*

ACTIVITY 2: ASSESS THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	Reliability of the survey is documented. Documentation: *Morpace 2018 CAHPS® Child CCC Medicaid Survey Summary Report*
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	Validity of the survey and responses are documented. Documentation: *Morpace 2018 CAHPS® Child CCC Medicaid Survey Summary Report*

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments And Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Definition of the study population was clearly defined. Documentation: *Morpace 2018 CAHPS® Child CCC Medicaid Survey Summary Report*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Specifications for sample frame were clearly defined. Documentation: *Morpace 2018 CAHPS® Child CCC Medicaid Survey Summary Report*
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	The sampling strategy was appropriate. Documentation: *Morpace 2018 CAHPS® Child CCC Medicaid Survey Summary Report*
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**MET**	The required sample size is 1,350 according to NCQA. ATC had a sample size of 3,490. Documentation: *Morpace 2018 CAHPS® Child CCC Medicaid Survey Summary Report*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Appropriate procedures were used to select the sample. Documentation: *Morpace 2018 CAHPS® Child CCC Medicaid Survey Summary Report*

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments And Documentation
4.1	Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	Specifications for calculating raw and adjusted response rates were aligned with NCQA protocol, and are clear and appropriate. Documentation: *Morpace 2018 CAHPS® Child CCC Medicaid Survey Summary Report*
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**MET**	Response rate was evaluated, and implications of response rate are noted. Documentation: *Morpace 2018 CAHPS® Child CCC Medicaid Survey Summary Report* *December 2018 QIC Minutes*

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	A Quality Assurance Plan was in place. Documentation: *Morpace 2018 CAHPS® Child CCC Medicaid Survey Summary Report*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the planned approach. Documentation: *Morpace 2018 CAHPS® Child CCC Medicaid Survey Summary Report*
5.3	Were confidentiality procedures followed?	**MET**	Confidentiality procedures were followed. Documentation: *Morpace 2018 CAHPS® Child CCC Medicaid Survey Summary Report*

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	**MET**	Data were analyzed. Documentation: *Morpace 2018 CAHPS® Child CCC Medicaid Survey Summary Report*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests were conducted. Documentation: *Morpace 2018 CAHPS® Child CCC Medicaid Survey Summary Report*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Survey conclusions were supported by findings. Documentation: *Morpace 2018 CAHPS® Child CCC Medicaid Survey Summary Report*

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	•The use of a CAHPS certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys. •Morpace as a vendor provides a full report of process and results that meets the necessary requirements and expectations of a survey report.
7.2	Identify the technical weaknesses of the survey and its documentation.	No technical weaknesses were noted in the review.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The overall response rate was 20% (n=709 valid surveys). The target response rate according to NCQA is 40.0%. The target number of valid surveys (n=411) was met, but the NCQA target response rate was not met. The response rate was slightly below the 2017 NCQA National average response rate for total sample (22%).
7.4	What conclusions are drawn from the survey data?	For Child with CCC CAHPS, key topic is Treated You with Courtesy and Respect (Customer Service Composite). Documentation: *QIC 2018 Minutes*
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	Assessment of access, quality, and timeliness is encompassed in the results of CAHPS survey. Documentation: *Morpace 2018 CAHPS® Child CCC Medicaid Survey Summary Report*
7.6	Comparative information about all MCOs (as appropriate).	Comparative information was provided and documented. Documentation: *Morpace 2018 CAHPS® Child CCC Medicaid Survey Summary Report*

D. Attachment 4: Tabular Spreadsheet

CCME MCO Data Collection Tool

Plan Name:	**Absolute Total Care**
Collection Date:	2018

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I. ADMINISTRATION						
I A. General Approach to Policies and Procedures						
1. The MCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					Policies are organized by department or functional area within the organization, reviewed annually, and updated as needed. The Archer Policy Management system is used to house and manage policies and provides a centralized location for staff to access policies. In addition to local plan policies, corporate policies are used sometimes and typically contain appendices or addenda to define South Carolina requirements and processes.
I B. Organizational Chart / Staffing						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO's resources are sufficient to ensure that all health care products and services required by the State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles:						
1.1 *Administrator (CEO, COO, Executive Director);	X					ATC's President & CEO is John McClellan.
1.2 Chief Financial Officer (CFO);	X					The Chief Financial Officer is Rodney Gaw.
1.3 * Contract Account Manager;	X					Tracy Roakes is the Contract Account Manager.
1.4 Information Systems personnel;						Most Information Systems functions are conducted at the corporate level with local Information Technology support.
1.4.1 Claims and Encounter Manager/ Administrator,	X					Cynthia Jones oversees claims functions, and Larry Barr oversees encounter functions.
1.4.2 Network Management Claims and Encounter Processing Staff,	X					
1.5 Utilization Management (Coordinator, Manager, Director);	X					Joyce McElwain is the Interim Vice President of Medical Management. ATC is seeking candidates to fill this position on a permanent basis. Natalie Crumpton is Director of Utilization Management. Shanta Aaron is Director of Clinical Behavioral Health, and Christy Vann is Director of Medicaid Case Management.
1.5.1 Pharmacy Director,	X					Jenna Meisner, Senior Director, Pharmacy, is licensed as a pharmacist by the South Carolina Board of Pharmacy.
1.5.2 Utilization Review Staff,	X					Utilization Review functions are conducted locally, and sufficient staff is in place.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5.3 *Case Management Staff,	X					All Case Managers are located in South Carolina.
1.6 *Quality Improvement (Coordinator, Manager, Director);	X					Joyce McElwain is the Senior Vice President of Quality Improvement. Managers of Quality Improvement and the Manager of Accreditation were identified on the organizational chart.
1.6.1 Quality Assessment and Performance Improvement Staff,	X					No vacancies are noted in Quality Improvement positions. Several positions are filled by temporary staff.
1.7 *Provider Services Manager;	X					Donald Pifer is the Vice President of Network Development and Credentialing. Melody Martin and Wanda Newkirk are Directors, Provider Network.
1.7.1 *Provider Services Staff,	X					
1.8 *Member Services Manager;	X					The Manager of Customer Service was identified on the organizational chart. Onsite discussion confirmed the Senior Director of Customer Service position was eliminated and a second Manager, Customer Services position created; ATC is interviewing candidates to fill this position.
1.8.1 Member Services Staff,	X					
1.9 *Medical Director;	X					ATC is recruiting for a newly-created Chief Medical Director position. Medical Directors include Dr. Cheryl Walker-McGill, Dr. William Logan, and Dr. Robert Thompson. ATC currently has four part-time Physician Consultants. All are licensed by and located in South Carolina.
1.10 *Compliance Officer;	X					Talvin Herbert is Vice President, Compliance and ATC's Compliance Officer.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.10.1 Program Integrity Coordinator;	X					Regina Moore is the Program Integrity Coordinator.
1.10.2 Compliance /Program Integrity Staff;	X					
1.11 * Interagency Liaison;	X					Susan O'Dwyer is Interagency Liaison.
1.12 Legal Staff;	X					
1.13 Board Certified Psychiatrist or Psychologist;	X					Dr. Frank Shelp is a board-certified Psychiatrist licensed by the South Carolina Board of Medical Examiners.
1.14 Post-payment Review Staff.	X					
2. Operational relationships of MCO staff are clearly delineated.	X					An organizational chart was provided but does not reflect current information for a few positions. Per onsite discussion, Centene Corporation is not in favor of using organizational charts and other processes are in place to track and display organizational structures and reporting hierarchies.
I C. Management Information Systems						
1. The MCO processes provider claims in an accurate and timely fashion.	X					ATC did not provide actual clean claim payment performance for 30 and 90 days, but *Information Systems Capabilities Assessment* (ISCA) documentation states claims are regularly audited. The ISCA response noted, "Performance results as of April 2018 were financial accuracy of 96.8% and payment accuracy of 96.1%." Internal benchmarks for paying claims are: •100% of clean claims finalized to a paid or denied status 30 calendar days from receipt

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•99% of non-clean claims finalized to a paid or denied status 60 calendar days from receipt •100% of all claims, including adjustments, processed and paid 90 calendar days from receipt CCME noted ATC's internal claims audit results are compiled into monthly reports. ATC's documentation states a claims management team is assigned to review claims processing to ensure adherence to requirements. *Recommendation: Include actual 30 day and 90-day clean claims payment performance in future ISCA review documentation.*
2. The MCO is capable of accepting and generating HIPAA compliant electronic transactions.	X					ATC's documentation describes systems capable of handling HIPAA-compliant electronic transactions. Supporting data was provided that reported 98% of all claims submitted to ATC were done so electronically.
3. The MCO tracks enrollment and demographic data and links it to the provider base.	X					ATC leverages 834 Medicaid ID information to generate a unique member identification that is used to track enrollees throughout multiple systems. ATC uses system-generated reports to assist in identifying potential duplicate members. If a duplicate is identified, the two profiles are merged and can be tracked by either of the previous Medicaid IDs.
4. The MCO's management information system is sufficient to support data reporting to the State and internally for MCO quality improvement and utilization monitoring activities.	X					ISCA documentation indicates that ATC is capable of collecting and storing claims data used to generate state-required HEDIS or HEDIS-like reports.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract.	X					ATC submitted a number of policies, practices, and procedure documents for the ISCA. Those documents indicate a focus on electronic and physical security controls. Many of the policy and procedure documents have recent revision timestamps that indicate documentation is reviewed and updated regularly.
6. The MCO has policies, procedures and/or processes in place for addressing system and information security and access management.	X					ATC's access control policies require system access to be administered on the principal of least privilege. Additionally, ATC uses predefined roles to apply access permissions consistently.
7. The MCO has a disaster recovery and/or business continuity plan that has been tested, and the testing has been documented.	X					ATC has a comprehensive disaster recovery plan that was revised recently. ATC tested the plan in August 2018 at a recovery site; the test resulted in the successful recovery of the data systems and applications within the organization's defined recovery time window.
I D. Compliance/Program Integrity						
1. The MCO has a Compliance Plan to guard against fraud and abuse.	X					ATC has a written *Compliance and Ethics Program Description*, a *Fraud, Waste and Abuse Plan*, and supplemental policies.
2. The Compliance Plan and/or policies and procedures address requirements, including:		X				Issues identified are detailed in the standards below.
2.1 Standards of conduct;						A formal *Business Ethics and Code of Conduct* (Code) is applicable to all employees of Centene Corporation and its subsidiaries. As a condition of employment, all employees must complete and sign an acknowledgment of receipt and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						understanding of the Code and must complete a *Conflict of Interest Disclosure* annually. Compliance training includes the Code.
2.2 Identification of the Compliance Officer and Program Integrity Coordinator;						The *Compliance and Ethics Program Description* identifies and defines the role of the Compliance Officer and includes information about some of the functions conducted by the Program Integrity Coordinator.
2.3 Inclusion of an organization chart identifying names and titles of all key staff;						
2.4 Information about the Compliance Committee;						
2.5 Compliance training and education;						The *Compliance and Ethics Program Description* includes information about mandatory compliance training and defines topics covered in the training. Training is provided upon hire and annually, thereafter. Members of ATC's Board of Directors must acknowledge receipt of the *Business Ethics and Conduct* policy and give written assurance they will abide by the policy. The *Compliance and Ethics Program Description* states training on identifying and reporting fraud, waste, and abuse (FWA) will be provided to ATC's contracted providers as necessary or upon request.
2.6 Lines of communication;						ATC requires employees to report all suspected or confirmed compliance issues and suspected or actual FWA to management or the Compliance Officer. Additional reporting methods include an Ethics and Compliance Helpline and a Fraud,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Waste, and Abuse Helpline that allow anonymous reporting. In addition to the *Compliance and Ethics Program Description,* information and guidance for reporting actual or suspected violations are found in *Policy CC.COMP.03, Speaking Up: Reporting Concerns, Policy Violations, Misconduct and Non-compliance* and *Policy CC.COMP.05, Prohibiting Retaliation Against Employees Individuals or Others.* ATC's provider contracts require providers to report incidents of potential FWA and reporting procedures are outlined in the *Provider Manual.*
2.7 Enforcement and accessibility;						The *Compliance and Ethics Program Description* refers the reader to *Policy CC.HUMR.17, Discipline* for information about disciplinary actions for failing to comply with the company's standards, policies, applicable statutes, and regulations. Review of *Policy CC.HUMR.17* revealed the policy title is "Performance Management" instead of "Discipline." All levels of employees are subject to the same disciplinary action for the commission of similar offenses, and disciplinary standards are communicated to employees at hire and again during Compliance and Ethics training sessions. *Recommendation: In the Compliance and Ethics Program Description (page 9), update the reference to Policy CC.HUMR.17 with the correct policy name.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.8 Internal monitoring and auditing;						ATC's parent company, Centene Corporation, periodically audits and monitors provider claims for compliance with established billing practices, regulations, and payor requirements. Centene's Special Investigation Unit (SIU) has dedicated staff and data systems to detect billing irregularities and other fraudulent or abusive billing practices. The Compliance Department audits ATC operations and functional departments for compliance with contractual requirements and applicable laws. A monthly risk report of non-compliance is distributed to Senior Management and the Corporate Compliance Department. The Compliance Officer and other management staff take immediate steps to correct identified issues and prevent them from recurring.
2.9 Response to offenses and corrective action;						Allegations or suspicions of noncompliance or other illegal or improper activities by employees, subcontractors, and providers are investigated promptly. If a violation is confirmed, the Compliance Officer takes immediate action to correct the issue and develops an appropriate corrective action to prevent further occurrences, which can include referral to law enforcement, termination from the provider network, and reporting to applicable state or federal authorities.
2.10 Data mining, analysis, and reporting;						Activities include claim edits, pre-payment and post-processing claim review, provider profiling, monitoring over and under-utilization, monitoring grievances and appeals, employee, provider and subcontractor training, and member education.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.11 Exclusion status monitoring.						The *Compliance and Ethics Program Description* states, "ATC will check federal and state exclusion/termination/suspension/prepayment databases on a regular basis to determine whether providers have been sanctioned or lost their professional license due to Medicaid fraud." *Attachment Q* (page 90) of the *Fraud, Waste, and Abuse Plan* mentions conducting initial and monthly queries of the OIG LEIE website for all employees and subcontractors. The attachment also mentions checking providers and subcontractors at enrollment against the General Services Administration's (GSA's) Excluded Parties List Service (EPLS). There is no mention of checking this at any time other than at enrollment. Of note, the GSA's EPLS was changed to the System for Award Management (SAM) in 2012. *Policy CC.COMP.36, Monthly Employee, Vendor, and Board Member Exclusion Screening* provides instruction for performing exclusion status monitoring of employees, vendors, and board members. A vendor (OIG Compliance Now) performs this function for ATC. The policy does not address the Social Security Administration's Death Master File (SSDMF). Also, it does not address the databases required by SCDHHS Program Integrity: the SC List of Providers Terminated for Cause, Suspended List, Behavioral Health Actions List, and Excluded Provider List. *Quality Improvement Plan: Revise Policy CC.COMP.36 and Attachment Q of the Fraud,*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Waste, and Abuse Plan to include all required queries and the frequency of all queries conducted to ensure employees, providers, and subcontractors are eligible to participate in Federal health care programs. Correct the reference to the EPLS in Attachment Q of the Fraud, Waste, and Abuse Plan.
3. The MCO has an established committee responsible for oversight of the Compliance Program.	X					ATC's Compliance Committee is chaired by the Compliance Officer. The *Compliance Committee Charter* indicates the committee meets at least quarterly and defines the quorum and attendance expectations for members. The 2018 Compliance Committee minutes reveal the second quarter meeting was not held until the third quarter; ATC provided an explanation during the onsite discussion. Discrepancies in documentation of the Compliance Committee's membership are noted in the following: •*Compliance Committee Charter* •*2018 Compliance Committee Members* list •*Compliance and Ethics Program Description* (page 7) •Compliance *Committee Agenda* (September 28, 2018) *Recommendation: Ensure Compliance Committee meetings are held at least quarterly, as required by the Compliance Committee Charter, or document the reason a meeting is not held or is held late. Revise all documents that list the membership of the Compliance Committee for consistency.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The MCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					As noted in the *Fraud, Waste, and Abuse Plan* and related policies: •Centene's Claim Audit Department conducts pre-payment and post-payment claims audits and related systems on behalf of ATC. •Multiple methods are in place to report suspected or actual violations by ATC. •Mechanisms are in place to ensure confidentiality and anonymity of those making reports. •Data mining systems and processes are in place to validate, trend, and query claims to identify fraud, waste, and abuse.
5. The MCO's policies and procedures define how investigations of all reported incidents are conducted.	X					The Corporate SIU and ATC work together to ensure all investigations are accurate and timely. The *Fraud, Waste, and Abuse Plan* provides detailed descriptions of investigative processes for both pre-payment review and investigations of suspected FWA. Upon completion of a review or investigation, established guidelines are followed for reporting. The *Fraud, Waste, and Abuse Plan, Attachment Q, South Carolina – State Specific Guidelines* defines reporting requirements for South Carolina.
6. The MCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					*Policy SC.CLMS.01, ATC State Suspended Provider Payment Withhold* defines procedures and requirements for instituting payment suspensions for providers against whom SCDHHS has determined a credible allegation of fraud. Processes for post-payment recoupment of provider payments are included in *Fraud, Waste, and Abuse Plan*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy SC.FINC.02, Post-Payment Recovery Requirement states the purpose of the policy is to outline the procedure for post-payment recouping but provides minimal information. It states, "If a claim is recouped in full any encounters for that claim will be voided." and "If there is an adjusted claim a replacement encounter will be submitted for the adjusted claim." The *Fraud, Waste, and Abuse Plan* states the health plan sends *Explanations of Benefits* to members to identify phantom providers or services not performed. Detailed information about this process is found in *Policy CC.COMP.16.01, EOB Service Verification*. *Recommendation: To fulfill the stated purpose of the policy, revise Policy SC.FINC.02 to include full information about procedures for post-payment recoupment.*
7. The MCO implements and maintains a statewide Pharmacy Lock-In Program (SPLIP).	X					ATC has an established Pharmacy Lock-In Program as described in *Policy SC.PHAR.06, Pharmacy Lock-In Program*.
I E. Confidentiality						
1. The MCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					Page 1 of *Policy CC.COMP.10, Annual Compliance Training* states, "The Workforce will receive training regarding the privacy and confidentiality of individual health information within ten (10) days of initial employment." Onsite discussion confirmed confidentiality training is provided on the first day of

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						employment prior to granting access to protected health information. *Recommendation: Revise Policy CC.COMP.10, Annual Compliance Training to include a statement that all employees receive confidentiality training prior to being granted access to protected health information.*

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II. PROVIDER SERVICES						
II A. Credentialing and Recredentialing						
1. The MCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements.		X				ATC conducts the functions of practitioner selection and retention as defined in *Policy CC.CRED.01, Practitioner Credentialing & Recredentialing*. The policy is detailed and addresses South Carolina specific requirements through footnotes and *Attachment J*. The following issues were identified: •Page 31, footnote 87 incorrectly references the South Carolina *2016 MCO Contract*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•Page 20 (footnote 52) and *Attachment J* do not address all Program Integrity (PI) queries required by SCDHHS, such as the Suspended List and the Behavioral Health Actions List. *Quality Improvement Plan: For Policy CC.CRED.01, Practitioner Credentialing & Recredentialing correct the 2016 MCO Contract reference and ensure all the PI queries required by SCDHHS are addressed in the policy.*
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the MCO.	X					*Policy CC.CRED.03, Credentialing Committee* outlines the oversight authority, composition, and responsibilities of the Credentialing Committee. The Credentialing Committee meets monthly and is chaired by Dr. Robert Thompson, Medical Director. Dr. Cheryl Walker-McGill, Medical Director, serves as an alternate and attends meetings rarely. Additional voting members include four network providers with specialties in pediatrics, surgery, and psychiatry. A quorum is met with 2/3 of voting members in attendance. Meeting minutes reflect a quorum was met during each meeting.
3. The credentialing process includes all elements required by the contract and by the MCO's internal policies.	X					Credentialing files are organized and for the most part contain appropriate documentation. Any issues are discussed below.
3.1 Verification of information on the applicant, including:						
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.2 Valid DEA certificate and/or CDS certificate;	X					
3.1.3 Professional education and training, or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					
3.1.5 Malpractice claims history;	X					
3.1.6 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application;	X					
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.8 No debarred, suspended, or excluded from Federal procurement activities: Query of System for Award Management (SAM);	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.10 Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause list; and the CMS Adverse Action Report List;		X				Credentialing files do not show evidence the following PI queries required by SCDHHS were performed: Suspended List and Behavioral Health Actions List. The plans are no longer required to query the CMS Adverse Action Report List per SCDHHS. *Quality Improvement Plan: Ensure credentialing files contain proof of all Program Integrity queries required by SCDHHS.*
3.1.11 Query for Medicare and/or Medicaid sanctions (5 years); OIG List of Excluded Individuals and Entities (LEIE);	X					
3.1.12 Query of Social Security Administration's Death Master File (SSDMF);	X					
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES);	X					
3.1.14 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
3.1.15 Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures;	X					One credentialing file does not contain a copy of the Clinical Laboratory Improvement Amendment (CLIA) certificate even though the provider indicated on the application that laboratory services were provided. All other files contain CLIA certificates, if applicable.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Ensure CLIA certificates are collected for providers that indicate they provide laboratory services.
3.1.16 Ownership Disclosure form.	X					
3.2 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the MCO's internal policies.	X					Recredentialing files are organized and for the most part contain appropriate documentation. Any issues are discussed below.
4.1 Recredentialing conducted at least every 36 months;	X					
4.2 Verification of information on the applicant, including:						
4.2.1 Current valid license to practice in each state where the practitioner will treat members;	X					
4.2.2 Valid DEA certificate and/or CDS certificate;	X					
4.2.3 Board certification if claimed by the applicant;	X					
4.2.4 Malpractice claims since the previous credentialing event;	X					
4.2.5 Practitioner attestation statement;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.6 Requery the National Practitioner Data Bank (NPDB);	X					
4.2.7 Requery of System for Award Management (SAM);	X					
4.2.8 Requery for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
4.2.9 Requery of the State Excluded Provider's Report, the SC Providers Terminated for Cause list, and the CMS Adverse Action Report List;		X				Recredentialing files do not show evidence the following PI queries required by SCDHHS are performed: Suspended List and Behavioral Health Actions List. The plans are no longer required to query the CMS Adverse Action Report List per SCDHHS. *Quality Improvement Plan: Ensure recredentialing files contain proof of all Program Integrity queries required by SCDHHS.*
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event; OIG List of Excluded Individuals and Entities (LEIE);	X					
4.2.11 Query of the Social Security Administration's Death Master File (SSDMF);	X					
4.2.12 Query of the National Plan and Provider Enumeration System (NPPES);	X					One recredentialing file does not contain a copy of the query of the National Plan and Provider Enumeration System (NPPES). All other recredentialing files are documented appropriately.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Ensure files contain proof of query of the NPPES.
4.2.13 In good standing at the hospitals designated by the provider as the primary admitting facility;	X					
4.2.14 Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures;	X					
4.2.15 Ownership Disclosure form.	X					
4.3 Review of practitioner profiling activities.	X					*Policy CC.CRED.01, Practitioner Credentialing & Recredentialing* states the recredentialing process considers provider-specific performance data such as those collected through the quality improvement program, the utilization management system, the grievance/complaint system, satisfaction surveys, and other activities of the organization. The information is gathered from the QI Department designee for inclusion in the recredentialing file. Evidence of performance data consideration is included in the recredentialing files. ATC provides physician profiling or provider report cards which include specific HEDIS measures with comparison of the practice to ATC's overall health plan score.
5. The MCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the MCO for serious quality of care or service issues.	X					*Policy CC.CRED.07, Practitioner Disciplinary Action and Reporting* defines the procedures for disciplinary actions including suspension, restrictions, or termination based on non-compliance with minimum credentialing

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						requirements, or if imminent harm to patient health, fraud, or malfeasance is suspected. Disciplinary action is determined by the plan Medical Director or Credentialing Committee. If the suspension or termination is based on issues of quality of care or services, the practitioner is notified about an appeal process. Adverse actions are reported to the NPDB and state licensure board, as appropriate.
6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities.		X				The credentialing/recredentialing procedures for healthcare delivery organizations are addressed in *Policy CC.CRED.09, Organizational Assessment and Reassessment*. The policy is detailed, and South Carolina specific guidelines are addressed in *Attachment M*; however, the policy does not address all the PI queries required by SCDHHS, such as the Suspended List and the Behavioral Health Actions List. A review of organizational credentialing and recredentialing files shows the files are organized but no queries were performed for the Suspended List and the Behavioral Health Actions List. *Quality Improvement Plan: Update Policy CC.CRED.09, Organizational Assessment and Reassessment, Attachment M, to include the Suspended List and the Behavioral Health Actions List as required queries.*
7. Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds.		X				The process for ongoing monitoring for practitioner sanctions, exclusions, complaints, and quality issues between recredentialing cycles is addressed in *Policy CC.CRED.06, Ongoing Monitoring of Sanctions & Complaints*. Ongoing

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						monitoring is performed monthly by the Credentialing Department. The policy is detailed, and *Attachment J* specifies South Carolina criteria; however, the policy does not address all the PI queries required by SCDHHS, such as the Suspended List, and the Behavioral Health Actions List. *Quality Improvement Plan: Update Policy CC.CRED.06, Ongoing Monitoring of Sanctions & Complaints, Attachment J to include the Suspended List and the Behavioral Health Actions List as required queries.*
II B. Adequacy of the Provider Network						
1.The MCO maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements.						
1.1 Members have a primary care physician located within a 30-mile radius of their residence.	X					*Policy CC.PRVR.47, Evaluation of Practitioner Availability* defines the mechanism used to monitor the type, number and geographic distribution of primary care providers, high-volume and high-impact specialty care practitioners, and high-volume behavioral health practitioners to monitor network adequacy. ATC assesses the availability of PCPs within network by practitioner type: family/general practitioners, internists, and pediatricians. Family practice and general practitioners may be assessed separately or combined. Data sources may include but are not limited to: network adequacy reports/Geo Access mapping and self-reported member data

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						such as satisfaction survey results and/or complaints/grievances regarding satisfaction with practitioner availability. *Policy CC.PRVR.47, Evaluation of Practitioner Availability* and *Policy SC.CONT.02, Network Adequacy* define the geographic standards for PCPs as 1 within 30 miles or 45 minutes, which complies with contract guidelines. The 2017 Practitioner Availability Analysis Report shows the goal of 95% compliance with the PCP geographic standards is met in all regions. Results of GEO Access reports dated 12/11/18 show 100% access for family/general practice and internal medicine and 99.9% access for pediatrics.
1.2 Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty.	X					*Policy SC.CONT.02, Network Adequacy* defines the access standards for Medicaid Specialists and Medicaid Hospitals as one within 50 miles and 75 minutes. *Policy CC.PRVR.47, Evaluation of Practitioner Availability* defines the mileage requirements for high-volume and high-impact specialists as one within 50 miles and 75 minutes or less drive time. GEO Access Reports reflect appropriate provider availability standards measurement for specialists. The 2017 Practitioner Availability Analysis Report shows the identified high-volume specialty is Obstetrics/Gynecology and the high-impact specialist is Hematology/Oncology. High-volume behavioral health practitioners identified by the QIC based on claims data are Psychiatrists and Psychologists. Results show ATC's geographic

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						standard of 95% of its members having at least one high-volume specialty practitioner (OB/GYN) within 30 miles or 45 minutes is not met due to Region 5 (94%). ATC's geographic standard of 99% of its members having at least one high-impact specialty practitioner (Hematology/Oncology) within 50 miles or 75 minutes is also not met due to Region 5 (97.9%) and Region 6 (96.1%). Availability for behavioral health care types by specific type (i.e. Psychiatrists, Psychologists and Master Level Clinicians) all meet the availability standards. Barrier analysis was conducted with activities planned to address deficiencies.
1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually.	X					*Policy SC.CONT.02, Network Adequacy* states ATC analyzes its network adequacy on a bi-annual basis by running GEO Access Maps for all contracted PCPs, specialists, key ancillary services, and hospitals.
1.4 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					ATC assesses the cultural, ethnic, racial, and linguistic needs of its members annually. ATC offers language assistance services to members who do not speak English as a primary language. Services are available for both telephonic and on-site interactions. ATC also reviews language line utilization data to assess the linguistic needs of members. The *2018 Cultural Competency Plan* is listed on the ATC website and information is included in the *Provider Manual*.
1.5 The MCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The MCO maintains a provider directory that includes all requirements outlined in the contract.	X					ATC's online searchable *Provider Directory* is updated daily, and Customer Service Representatives print paper copies upon member request. The ATC *Evaluation of Accuracy of Online Provider Directory - 2018* report details a study conducted to ensure members have up-to date network provider contact information. ATC selected a random sample of 2,454 physicians from the Medicaid network and provider relations staff collected data by phone and from online surveys. The surveys included verification of data currently displaying on the ATC online provider directory, with the physician's office staff asked to confirm if the information was accurate. For the 2018 monitoring period, 2 out of 5 directory parameters meet the designated performance goal of 100%. The lowest performing parameters are "Awareness of physician office staff of which networks the practitioner participates in" (91%), "Office locations/addresses" (95%), and "Office phone numbers" (96%). Barrier analysis and planned activities (such as provider training) are discussed in the report.
3.Practitioner Accessibility						
3.1 The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	X					*Policy SC.QI.05, Evaluation of the Accessibility of Services* defines the procedures for monitoring member access to primary care services, behavioral health services, high-volume/high-impact specialists, and member services annually. The process includes evaluating results of the HEDIS/CAHPS survey, evaluating member

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						complaints/grievances, and conducting site specific audits regarding access for primary care, specialty, and behavioral health services. ATC conducted an appointment availability study in 2018. Overall results show pass rates ranging from 84% - 100% for the various categories. Emergent or emergency visits scored the lowest at 84% with barriers such as provider lack of knowledge of the appointment access standards identified. Opportunities exist to educate non-compliant offices and audit the provider again in 90 days, and for network-wide education about appointment access standards. Results of the 2018 After Hours Survey show a pass rate of 87% which is a 1% increase from the 2017 study.
3.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.	X					As part of the Annual EQR process for ATC, CCME performed a provider access study focused on primary care providers. ATC gave CCME a list of current providers, from which a population of 2,878 unique PCPs was found. A sample of 278 providers was randomly selected from the total population for the access study. Attempts were made to contact these providers to ask a series of questions regarding the access that members have with contracted providers. The results of the *Telephonic Provider Access Study* reflect calls answered successfully 60% of the time (148 out of 246) when omitting calls answered by personal or general voicemail messaging services. When compared to 2017

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						results of 51%, 2018 has a marginally significant increase in successful calls at 60% (p=.0526). For calls not answered successfully (n=98 calls), 56 (57%) were unsuccessful because the provider was not at the office or phone number listed. Of the 148 providers, 132 (89%) indicated they accept ATC, with five (3%) indicating this occurs only under certain conditions. Of 129 responses, 100 (78%) responded they are accepting new Medicaid patients. Regarding a screening process for new patients, 61 (59%) of the 104 providers who responded to the item indicated that an application or prescreen is necessary, with 13 (21%) indicating that an application must be filled out, 14 (23%) requiring a review of medical records before accepting a new patient, and 19 (31%) require both. When the office was asked about the next available routine appointment, 63 (76%) of the 83 responses met contract requirements.
II C. Provider Education						
1. The MCO formulates and acts within policies and procedures related to initial education of providers.	X					ATC conducts provider orientation for all newly contracted PCPs, specialists, hospitals, and ancillary providers within 30 business days of becoming active with ATC per *Policy SC.PRVR.13, Provider Orientations.* The *Provider Manual* is a good reference document for providers to navigate the plan. It is available on the website along with training and resource documents.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Initial provider education includes:						
2.1 MCO structure and health care programs;	X					
2.2 Billing and reimbursement practices;	X					
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS;	X					
2.4 Procedure for referral to a specialist;	X					
2.5 Accessibility standards, including 24/7 access;	X					
2.6 Recommended standards of care;	X					
2.7 Medical record handling, availability, retention and confidentiality;	X					
2.8 Provider and member grievance and appeal procedures;	X					
2.9 Pharmacy policies and procedures necessary for making informed prescription choices;	X					
2.10 Reassignment of a member to another PCP;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.11 Medical record documentation requirements.	X					
3. The MCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies and procedures.	X					*Policy SC.PRVR.14, Provider Visit Schedule/ Ongoing Education*, details the process for ensuring ongoing provider education through regularly scheduled, agenda-driven face-to-face visits conducted by Provider/Network Relations Specialists. PCPs receive visits quarterly and high-volume in-network specialists receive visits bi-annually. Ancillary provider visits are conducted as necessary. Additional information is distributed throughout the year through provider newsletters, bulletins, fax blasts, webinars, and the website.
II D. Primary and Secondary Preventive Health Guidelines						
1. The MCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					*Policy SC.QI.08, Clinical & Preventive Practice Guidelines*, states ATC adopts clinical and preventive practice guidelines for the provision of acute, chronic, and behavioral health services relevant to the populations served. Preventive practice guidelines for pediatric, adolescent, and adult populations are presented to the QIC for review, approval, and adoption. Guidelines are updated upon the discovery of significant new scientific evidence, changes in national standards, and reviewed at least every two years.
2. The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers.	X					Preventive guidelines are addressed in the *Provider Manual* available on the website; ATC provides a hard copy upon request.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Well child care at specified intervals, including EPSDTs at State-mandated intervals;	X					
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					
3.4 Adult screening recommendations at specified intervals;	X					
3.5 Elderly screening recommendations at specified intervals;	X					
3.6 Recommendations specific to member high-risk groups;	X					
3.7 Behavioral Health Services.	X					
II E. Clinical Practice Guidelines for Disease, Chronic Illness Management, and Behavioral Health Services						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO develops clinical practice guidelines for disease, chronic illness management, and behavioral health services of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists.	X					ATC adopts clinical and preventive practice guidelines for the provision of acute, chronic and behavioral health services relevant to the populations served as defined in *Policy SC.QI.08, Clinical & Preventive Practice Guidelines*. The guidelines are derived from recognized sources and are presented to the QIC for review, approval, and adoption.
2. The MCO communicates the clinical practice guidelines for disease, chronic illness management, and behavioral health services and the expectation that they will be followed for MCO members to providers.		X				Current preventive and clinical practice guidelines are available on the ATC provider website and may be mailed to practitioners as part of disease management or other quality program initiatives. The adopted clinical practice guidelines show inconsistencies between the website and *Provider Manual:* •The *Provider Manual*, page 26, shows "Quick Reference Guide Clinical Practice Guidelines for Standards of Medical Care in Diabetes – 2015," but the website shows "Diabetes Care: Standards of Medical Care in Diabetes, 2018." •The *Provider Manual*, page 27, shows "Diabetic Care: Summary of Revisions for the 2012 Practice Recommendations," but the website shows "Standards of Medical Care in Diabetes, 2018: Summary of Revisions." •The *Provider Manual*, page 26, lists "Physician Guidelines for Routine Antepartum Care," but this is not listed on the website. •The following guidelines are listed on the website but not mentioned in the *Provider Manual*: "Practice Parameter for the Assessment and Treatment of Children and Adolescents with Bipolar Disorder" and "Practice Guideline for the treatment of Patients with Substance Use Disorders."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Improvement Plan: Update the Provider Manual or the website to ensure all clinical practice guidelines are accurately reflected.
II F. Continuity of Care						
1. The MCO monitors continuity and coordination of care between the PCPs and other providers.	X					*Policy CC.QI.09, Continuity & Coordination Member Care* states that at least annually, the plan collects data to assess, identify, and act on at least four opportunities to improve coordination of medical care. Continuity and coordination of medical services involves the facilitation of members getting the care or services they need across transitions and settings of care, and practitioners/providers getting the information needed to provide appropriate care for members. Data are focused on coordination of medical care across settings and transitions in care. A summary including qualitative and quantitative analysis of the activity is presented to the *Quality Improvement Committee*. The 2017 continuity and coordination of medical care annual monitoring results are presented in the *Absolute Total Care Quality Assessment and Performance Improvement Program Evaluation - Medicaid 2017*. *Policy CC.QI.28, Continuity & Coordination Between Medical and Behavioral Health Care* states that at least annually the plan collaborates with behavioral health practitioners to evaluate the continuity and coordination of care between medical and behavioral health care providers. The plan analyzes results, develops interventions, and implements interventions when opportunities for

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						improvement are identified. Evidence of the annual assessment conducted for 2017 was presented to the QIC in April 2018.
II G. Practitioner Medical Records						
1. The MCO formulates policies and procedures outlining standards for acceptable documentation in the member medical records maintained by primary care physicians.	X					ATC monitors its practitioners to ensure that medical records are maintained in a detailed and organized manner and that patient confidentiality is preserved. *Policy SC.QI.13, Medical Record Review* details minimum standards for practitioner documentation. The information is also listed in the *Provider Manual* and on the website.
2. Standards for acceptable documentation in member medical records are consistent with contract requirements.	X					
3. Medical Record Audit						
3.1 The MCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers.	X					ATC assesses network medical record keeping practices annually against the established standards for selected Primary Care Physicians (PCP) and may include high-volume specialists (i.e. OB/GYN). The process is addressed in *Policy SC.QI.13, Medical Record Review*. Practitioners sampled must meet 80% of the requirements or be subject to corrective action. The 2018 annual audit report shows there were 67 individual practitioners with a total of 335 medical records reviewed. All 67 practitioners received a total passing score of 80% or greater. The average score for the 2018 audit year was 96% which represents a 1% increase from the 2017 audit

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						results of 95%. No practitioners were placed on a corrective action plan.
4. Accessibility to member medical records by the MCO for the purposes of quality improvement, utilization management, and/or other studies is contractually assured for a period of 5 years following expiration of the contract.	X					

III. MEMBER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III. MEMBER SERVICES						
III A. Member Rights and Responsibilities						
1. The MCO formulates and implements policies guaranteeing each member's rights and responsibilities and processes for informing members of their rights and responsibilities.	X					*Policy SC.MBRS.25, Member Rights and Responsibilities* lists member rights and defines how Absolute Total Care (ATC) advises members of their rights and responsibilities. Member rights are included in the *Member Handbook* provided at enrollment and members are informed of rights at

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						least yearly and when changes occur via a newsletter or a direct mailing. Providers are required to post member rights in their offices within sight of members.
2. Member rights include, but are not limited to, the right:	X					Member rights are consistently documented across *Policy SC.MBRS.25*, the *Member Handbook*, the *Provider Manual*, and on ATC's website.
2.1 To be treated with respect and with due consideration for dignity and privacy;						
2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.3 To participate in decision-making regarding their health care, including the right to refuse treatment;						
2.4 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with Federal regulations;						
2.5 To be able to request and receive a copy of the member's medical records and request that they be amended or corrected as specified in Federal regulation (45 CFR Part 164);						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.6 To freely exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO and its providers or the Department treat the Medicaid MCO Member.						
III B. Member MCO Program Education						
1. Members are informed in writing within 14 calendar days from the MCO's receipt of enrollment data of all benefits and MCO information including:	X					Members are provided a new member packet containing the *Member Handbook*, a *Frequently Asked Questions* document, *Provider Directory*, and Member ID Card within 7-14 days of ATC receiving the member's enrollment data from SCDHHS.
1.1 Benefits and services included and excluded in coverage;						The *Member Handbook* includes a table of services that are covered and not covered by ATC.
1.1.1 Direct access for female members to a women's health specialist in addition to a PCP;						
1.1.2 Access to 2nd opinions at no cost, including use of an out-of-network provider if necessary.						
1.2 How members may obtain benefits, including family planning services from out-of-network providers;						
1.3 Any applicable deductibles, copayments, limits of coverage, and maximum allowable benefits;						The *Member Handbook* includes limitations of coverage and applicable copayments. Copayments are also listed in the *Provider Manual* and on ATC's website.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The benefits grid in the *Member Handbook* (page 19) addresses Maternity Services and in the "Limitations" column states, "OB/GYN visits, etc." Members may misinterpret this to mean that ATC limits the number of OB/GYN visits, etc. The benefits grids in the *Member Handbook* and *Provider Manual* list "$0" for services that have no copayment. However, in both, the copayment field for infusion centers is blank. Onsite discussion confirmed there is no copayment for infusion centers. *Recommendation: Revise the information in the benefit grid's "Limitations" column for maternity services to remove the statement, "OB/GYN visits, etc." or explain any applicable limitations. Revise the tables in the Member Handbook (page 18) and Provider Manual (page 44) to indicate there is no copay for Infusion Centers.*
1.4 Any requirements for prior approval of medical or behavioral health care and services;						The *Member Handbook* indicates services which require prior authorization and instructs members to contact Member Services for questions about benefits. The *Provider Manual* includes information about prior authorization requirements and instructs providers to consult the online prior authorization tool on ATC's website for the most current information.
1.5 Procedures for and restrictions on obtaining out-of-network medical care;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services, including post-stabilization services;						The *Member Handbook* defines urgent and emergent care, informs that emergent care requires no prior authorization, and that emergent care can be provided by any hospital regardless of whether in or out of ATC's network. A brief definition of post-stabilization care is also provided.
1.7 Policies and procedures for accessing specialty care;						
1.8 Policies and procedures for obtaining prescription medications and medical equipment, including applicable restrictions;						Members are directed to the website to view the *Preferred Drug List* and find participating pharmacies or to contact Member Services to obtain this information. The *Member Handbook* includes information about obtaining prescription medications and durable medical equipment.
1.9 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network;						Members are informed how and when they will be notified of a provider's termination. The list of member rights includes the right to be notified of any significant changes to the benefits package at least 30 days before the intended effective date of the change.
1.10 Procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						
1.11 Procedures for disenrolling from the MCO;						
1.12 Procedures for filing grievances and appeals, including the right to request a Fair Hearing;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.13 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for their care and of alternate languages spoken by the provider's office;						Members are directed to the online "Find a Provider Tool" to obtain provider information such as name, address, phone number, alternate languages spoken, specialty, professional qualifications, and board certifications.
1.14 Instructions on how to request interpretation and translation services at no cost to the member;						
1.15 Member's rights, responsibilities, and protections;						
1.16 Description of the Medicaid card and the MCO's Medicaid Managed Care Member ID card, why both are necessary, and how to use them;						
1.17 A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;						
1.18 How to make, change, and cancel medical appointments and the importance of canceling and/or rescheduling appointments when necessary;						
1.19 Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;						A description of EPSDT services is provided as well as a schedule of recommended services from birth through 21 years of age.
1.20 A description of Advance Directives, how to formulate an advance directive, and how to receive assistance with executing an advance directive;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.21 Information on how to report suspected fraud or abuse;						Information on fraud, waste, and abuse (FWA) includes examples of fraud and reporting methods. Members may report suspicions of FWA by mail or email to ATC's Compliance Department and to the toll-free ATC Fraud and Abuse Hotline. Reports may also be submitted to the SCDHHS Division of Program Integrity by mail, email, or telephone. Contact information is provided for each reporting method.
1.22 Additional information as required by the contract and/or federal regulation;						
2. Members are notified at least once per year of their right to request a Member Handbook or Provider Directory.	X					
3. Members are informed in writing of changes in benefits and changes to the provider network.	X					The *SCDHHS Contract, Section 5.6.6.4* requires health plans to make a good faith effort to give written notice of termination of a contracted provider within 15 days after receipt or issuance of a termination notice to each member who received primary care from, or was seen on a regular basis by, the terminated provider. *Policy SC.ELIG.14, Member Notification of Provider Termination* documents the timeframe as it is stated within the *SCDHHS Contract*. However, different timeframes are documented in the following: •*Policy SC.MBRS.12, Enrollee Notification* states ATC makes every effort to ensure member notification of changes to providers at least 30 days before the changes are effective. •*Policy CC.PRVR.23, Provider Termination Policy* states the timeframe for written notice is at least

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						30 days prior to the effective date of the change, or otherwise as soon as feasible based on receipt of notice. *Recommendation: Review Policy SC.ELIG.14, Policy SC.MBRS.12, and Policy CC.PRVR.23 and revise as needed to clarify inconsistencies in the timeframes for member notification of a provider's termination.*
4. Member program education materials are written in a clear and understandable manner and meet contractual requirements.	X					
5. The MCO maintains, and informs members how to access, a toll-free vehicle for 24-hour member access to coverage information from the MCO.	X					The Member Services call center, located within ATC's office, is staffed from 8:00 am to 6:00 pm Monday through Friday. The call center is accessible through a toll-free telephone number. Members may send messages to Member Services using the secure member portal on ATC's website. An automated call system provides office hours, instructions for verifying eligibility, and emergency instructions. Members may leave voice messages for a response within 1 business day or transfer to the 24-hour Nurse Advice Line to obtain eligibility information, medical advice, health information, and help in determining where to go for care.
III C. Member Enrollment and Disenrollment						
1. The MCO enables each member to choose a PCP upon enrollment and provides assistance if needed.	X					The processes for PCP selection and auto-assignment are found in *Policy SC.ELIG.01, PCP Assignment*. If a member has not selected a PCP at enrollment, ATC auto-assigns the member to a PCP. ATC ensures members will not be assigned a

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						PCP that is more than 30 miles from the member's residence. Members may change their PCP at any time.
2. MCO-initiated member disenrollment requests are compliant with contractual requirements.	X					
III D. Preventive Health and Chronic Disease Management Education						
1. The MCO informs members of available preventive health and disease management services and encourages members to utilize these services.	X					Members are informed of the preventive health guidelines and encouraged to obtain the recommended services via the *Member Handbook*, website, mailings, reminder calls, etc. Members are instructed to go to ATC's website to view the guidelines or to call Member Services for more information. Members may have difficulty locating the guidelines on the website as they are found under the "Quality Improvement Program" section of the "Member Resources" area of the website. Also, the "Preventive Guidelines" listed on the website include *Practice Guideline for the Treatment of Patients with Substance Use Disorders,* which is a clinical practice guideline rather than a preventive health guideline. *Recommendation: Place preventive health guidelines in a more prominent location on the website to allow members to more easily find them. Remove Practice Guideline for the Treatment of Patients with Substance Use Disorders from the list of preventive health guidelines on the website.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The MCO tracks children eligible for recommended EPSDT services/immunizations and encourages members to utilize these benefits.	X					ATC identifies EPSDT-eligible members using sources such as claims, encounter, and pharmacy data. Quality Improvement Outreach Teams provide education about EPSDT services through mailings, live and automated telephonic outreach, Care Gap alerts on the member portal, and face-to-face interaction. Information provided includes the importance of preventive medical care, scheduling visits according to the Bright Futures/AAP Periodicity Schedule, how and where to access services, and that there is no cost for services. The *2017 Quality Assessment and Performance Improvement Program Evaluation – Medicaid* indicates barriers to the ESPDT program goals include difficulty contacting members due to outdated phone numbers and addresses and lack of desire to complete well visits. Interventions to address the barriers are documented in the evaluation and included in the *2018 Quality Improvement Work Plan*.
3. The MCO provides education to members regarding health risk factors and wellness promotion.	X					ATC's Member Connections Program provides members with face to face contact, outreach, and education about healthy lifestyles in the member's home or other community settings. Additional methods of providing education about risk factors and wellness include mailings, newsletters, and information placed in providers' offices.
4. The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in recommended care.	X					Information used to identify pregnant members includes claim and encounter data, hospital discharge data, UM data, ED utilization reports, enrollment data, member reporting, and *Notification of Pregnancy* form submission.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The Start Smart for Your Baby® program combines elements of care management, care coordination, and disease management to improve prenatal and postpartum care. Members in the Start Smart for Your Baby program receive enhanced member outreach, incentives, wellness materials, and intensive care management (if applicable).
III E. Member Satisfaction Survey						
1. The MCO conducts a formal annual assessment of member satisfaction with MCO benefits and services. This assessment includes, but is not limited to:	X					ATC contracts with Morpace, a certified CAHPS survey vendor, to conduct the both the Adult and Child *Member Satisfaction Surveys*.
1.1 Statistically sound methodology, including probability sampling to ensure it is representative of the total membership;	X					The Child survey response rate is unchanged at 22%, which is the national average rate. The Adult response rate is 19%, which is a decrease from the previous year's rate of 25%. The Children with Chronic Conditions response rate decreased to 20% from the 2017 rate of 22% for the total sample response rate. *Recommendation: Because low response rates affect generalizability of results, continue working with the vendor to increase response rates. Consider other options such as adding reminders to the call center and maximizing the oversampling to increase response rates.*
1.2 The availability and accessibility of health care practitioners and services;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 The quality of health care received from MCO providers;	X					
1.4 The scope of benefits and services;	X					
1.5 Claim processing procedures;	X					
1.6 Adverse MCO claim decisions.	X					
2. The MCO analyzes data obtained from the member satisfaction survey to identify quality issues.	X					Morpace summarizes and details all results from Child and Adult surveys. ATC analyzes the vendor's reports.
3. The MCO implements significant measures to address quality issues identified through the member satisfaction survey.	X					Quality Improvement Committee minutes from December 2018 and documentation in the *CAHPS Workbook 09-18* provide evidence of analysis, discussion, and development of initiatives to address problematic areas of member satisfaction. Interventions focused on items that are below standard.
4. The MCO reports the results of the member satisfaction survey to providers.	X					Survey results are presented to providers in the Winter 2018 *Provider Report* newsletter.
5. The MCO reports results of the member satisfaction survey and the impact of measures taken to address identified quality issues to the Quality Improvement Committee.	X					Quality Improvement Committee meeting minutes from December 2018 reflect discussion of CAHPS survey issues and action plans.
III F. Grievances						
1. The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with	X					ATC's processes for receiving and resolving member grievances are documented in *Policy SC.UM.11, Member Grievances*. Information about

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
contract requirements, including, but not limited to:						the grievance process is included in the *Member Handbook*, *Provider Manual*, and on ATC's website.
1.1 The definition of a grievance and who may file a grievance;	X					
1.2 Procedures for filing and handling a grievance;	X					*Policy SC.UM.11, Member Grievances* mentions a clinically urgent grievance process and states all clinically urgent grievances will be forwarded to a Medical Director for review and resolved within 72 hours; however, the policy does not provide enough information to fully understand the clinically urgent grievance process. Onsite discussion revealed this is an internal process and members cannot request expedited grievance processing. Staff can make the determination that a grievance is clinically urgent if the grievance involves medical issues. *Recommendation: Revise Policy SC.UM.11 to fully explain the clinically urgent grievance process, such as how determinations are made that a grievance is clinically urgent, who makes the determination that a grievance is clinically urgent, etc.*
1.3 Timeliness guidelines for resolution of a grievance;	X					
1.4 Review of grievances related to clinical issues or denial of expedited appeal resolution by a Medical Director or a physician designee;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5 Maintenance and retention of a grievance log and grievance records for the period specified in the contract.	X					
2. The MCO applies grievance policies and procedures as formulated.		X				CCME reviewed 22 grievance files, and all were found to have appropriate acknowledgement and resolution within the required timeframes; referrals were made for possible quality of care or service concerns when appropriate. A common issue identified in the grievance files is related to lack of provider re-education: •In three of the grievance files, members requested reimbursement for the cost of medications. For each of the three, the pharmacy failed to provide an emergency supply of medication that required prior authorization and required out-of-pocket payment from the members for the medication. Each of the members met with difficulty receiving reimbursement for the medications from ATC. There is no information in the files to indicate a referral was made to an appropriate ATC department or to Envolve Pharmacy Solutions to provide pharmacy re-education about the requirement to provide an emergency supply of medication. •One grievance was related to a provider's refusal to release the member's medical records due to a past-due balance. While the file notes indicate that per *South Carolina Code of Laws, Section 44-115-70*, records are not to be withheld because of unpaid medical bills, there is no indication in the file that the provider was educated about this requirement or that a referral was made to an appropriate department to re-educate the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						provider. In addition, this file was investigated as a balance-billing issue rather than the issue of refusal to provide medical records. The resolution notice did not address the member's complaint. *Quality Improvement Plan: When the need for provider re-education regarding plan policies and program requirements is identified, ensure grievance files contain documentation of re-education conducted by grievance staff or referrals to other appropriate departments to provide re-education. Ensure grievance investigations and resolutions address the issue about which the member filed the grievance.*
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Grievance data is reviewed by the Quality Improvement Department to identify trends and opportunities to improve quality of care and service. Grievance data is reported to appropriate committees such as the Quality Improvement and Utilization Management Committees, and CCME's review of committee minutes confirms discussion of grievance data. Reports of member grievances are provided quarterly to the Compliance Officer and to SCDHHS.
4. Grievances are managed in accordance with the MCO confidentiality policies and procedures.	X					

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV. QUALITY IMPROVEMENT						
IV A. The Quality Improvement (QI) Program						
1. The MCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to members.	X					ATC's *2018 Quality Assessment and Performance Improvement Description Medicaid* describes the program's quality improvement structure, function, scope, and goals as defined by the health plan. The Board of Directors (BOD) provides strategic direction and ultimate authority for the QI Program.
2. The scope of the QI program includes monitoring of provider compliance with MCO wellness care and disease management guidelines.		X				ATC measures provider compliance with adopted *Clinical and Preventive Practice Guidelines* at least annually as described in *Policy SC.QI.08, Clinical & Preventive Practice Guidelines*. The policy states "ATC measures practitioner compliance with at least two measures for each of the four clinical guidelines." The policy further indicates a total score of 80% compliance must be met or a corrective action plan will be required. Results of monitoring was only found for Diabetes, Asthma, and Well Child Visits. Diabetes and Asthma results showed the providers met the 80% compliance rate; however, the goal set for the Well Child Visits did not follow ATC's policy of 80% compliance. This goal was set at the 75th Quality Compass percentile. The results fell below this goal; however, corrective action was not documented. Envolve PeopleCare is responsible for measuring provider compliance with the Behavioral Health Clinical Practice guidelines. According the *Envolve PeopleCare 2018 Quality and Process Improvement*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Program Description, HEDIS measures are used to measure provider adherence to the Depression, ADHD, and Schizophrenia clinical practice guidelines. The program description also indicates the Clinical Practice Guidelines study is supported by *Policy CQI.129 – Clinical Practice Guidelines*; however, this policy was not provided by ATC for review. ATC provided results for the reporting period of January 1, 2017 through December 31, 2017. The results show that ATC met the target set for the Antidepressant measure, was below the target for the ADHD measure, and the data was not available for the Schizophrenia measure. The report did not address the interventions for the measure that was below the target and no explanation exists for the missing data. This was discussed during the onsite and ATC indicated they recognized these issues and plan to bring these activities and others back into the local health plan. *Quality Improvement Plan: Update Policy SC.QI.08, Clinical & Preventive Practice Guidelines to better reflect the monitoring process for the clinical and preventive guidelines or ensure the current monitoring process outlined in the policy is followed.*
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					
4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).	X					ATC maintains an annual QI workplan that provides ongoing progress on QI activities thought out the year. The work plan is updated at least twice a year and presented to the Quality Improvement Committee for review and approval. ATC provided the 2017 and 2018 work plans for this review.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV B. Quality Improvement Committee						
1. The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					The Quality Improvement Committee (QIC) continues to have authority and responsibility for the QI Program.
2. The composition of the QI Committee reflects the membership required by the contract.	X					The Medical Director chairs the QIC and functions as the designated physician actively involved in the QI Program. The membership of the QIC includes network providers from primary and specialty care, senior leadership, and other department representatives.
3. The QI Committee meets at regular quarterly intervals.	X					QIC meets no less than quarterly.
4. Minutes are maintained that document proceedings of the QI Committee.	X					Minutes are drafted for each meeting, reviewed, and approved at the next regularly scheduled meeting. ATC submitted QIC minutes for meetings held in March 2018 – August 2018 for review.
IV C. Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					ATC uses Inovalon, a certified software organization, for calculation of HEDIS rates and met the validation requirements. Details of the validation of the performance measures may be found in the *CCME EQR Validation Worksheets, Attachment 3.* Comparison from the previous to the current year revealed a strong increase (>10%) in several rates, including BMI Percentile, Counseling for Nutrition, Counseling for Physical Activity, and Asthma Medication Compliance for 19-50-year-olds. The Persistence of Beta-Blocker Treatment After a Heart Attack measure decreased substantially (>10%).
IV D. Quality Improvement Projects						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population.	X					ATC submitted four projects. They included Improving Dilated Retinal Exam Screening, Post-Partum Care, Member Satisfaction and Provider Satisfaction.
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	X					Improving Dilated Retinal Exam Screening and the Member Satisfaction PIPs were retired in August 2018 and therefore not validated. The Post-Partum Care and Provider Satisfaction PIPs were validated using the CMS Protocol for Validation of Performance Improvement Projects. Both projects received a score within the "High Confidence in Reported Results" range and meet the validation requirements. Details of the validation of the PIPs are found in the *CCME EQR Validation Worksheets, Attachment 3.*
IV E. Provider Participation in Quality Improvement Activities						
1. The MCO requires its providers to actively participate in QI activities.	X					
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					Specific quality measures are incorporated into the primary care provider's report cards and distributed to providers annually. Information regarding the QI program is also posted on the ATC website.
IV F. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					ATC evaluates the effectiveness of its QI Program annually. For this review, the health plan provided the *Quality Assessment and Performance Improvement Program Evaluation - Medicaid 2017*. This report

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						provides an assessment of the results of the QI activities conducted in 2017.
2. The annual report of the QI program is submitted to the QI Committee and to the MCO Board of Directors.	X					

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V. Utilization Management						
V A. The Utilization Management (UM) Program						
1. The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					The *Utilization Management Program Description* outlines the goals, scope, staff roles for physical and behavioral health (BH) and pharmaceutical services for members in South Carolina. Several policies, such as *CC.UM.02.01, Medical Necessity Review*, *CC.UM.04, Appropriate UM Professionals*, and *SC.UM.39, Mixed Behavioral Health/Medical Services* provide guidance on utilization management (UM) processes and requirements.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 structure of the program and methodology used to evaluate the medical necessity;	X					
1.2 lines of responsibility and accountability;	X					
1.3 guidelines / standards to be used in making utilization management decisions;	X					
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;		X				*Policy SC.UM.05, Timeliness of UM Decisions and Notifications*, the *Provider Manual*, the *Member Handbook*, and the *UM Program Description* indicate ATC may extend expedited service authorizations for an additional 48 hours when requested by the member, provider, or the member's authorized representative. The *SCDHHS Contract, Section 8.6.2.3* allows 14 calendar days for member-requested extensions. During the onsite visit, CCME found timeframes for BH services authorizations were not identified. ATC provided *EPC.UM.01, Behavioral Health Utilization Management Program Description 2018*, in which service authorization timeframes are not identified. *Quality Improvement Plan: Revise the Provider Manual (pg. 7), Member Handbook (pg. 27), Program Description (pg.20) and Policy SC.UM.05, Timeliness of UM Decisions and Notifications (pg.3) to indicate expedited service authorizations can be extended up to 14 calendar days, if requested by the member, as required in the SCDHHS Contract, Section 8.6.2.3. Document BH service authorization timeframes in a policy to meet requirements in the SCDHHS Contract, Section 8.6.1.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5 consideration of new technology;	X					
1.6 the absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services;	X					
1.7 the mechanism to provide for a preferred provider program.	X					
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The *UM Program Description* indicates the Medical Director oversees the UM Program and responsibilities include, but are not limited to, supervising medical necessity decisions, conducting Level II reviews, and providing oversight to UMC, QIC, and all other physician committees or subcommittees. Operating authority is delegated to the VP of Medical Management and Director of UM who are both registered nurses. A registered pharmacist (RPh) oversees pharmacy services and a Medical Director with a specialty in psychiatry oversees BH services.
3. The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					At least annually the UM program is evaluated by the Medical Director, VP of Medical Management, and Director of Utilization Management to assess its strengths and effectiveness. The evaluation and recommendations are submitted to the Utilization Management Committee (UMC) for review and approval annually. The UMC consists of representatives from the provider network who participate in and provide input for the UM Program. Additionally, the UMC is responsible for evaluating clinical guidelines and adoption of medical necessity criteria.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V B. Medical Necessity Determinations						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					ATC uses InterQual Criteria™ and internal clinical policies for physical health, behavioral health, medical pharmacy benefits, durable medical equipment, and devices. Policies such as *CC.UM.02, Clinical Decision Criteria and Application, CP.MP.68, Medical Necessity Criteria* and the *UM Program Description* list nationally recognized clinical support tools and evidence-based criteria used for determining medical necessity. Individual circumstances and the local delivery system are considered when determining medical appropriateness.
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					Review of 15 UM approval files reflect consistent decision-making using criteria and relevant medical information, as described in the *UM Program Description, Policy CC.UM.02, Clinical Decision Criteria and Application,* and *Policy CC.UM.02.01, Medical Necessity Review*. Member-specific needs are appropriately considered.
3. Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations.	X					The processes for covering hysterectomies, sterilizations, and abortions are described in *Policy SC22-HS-UM-030, Hysterectomies, Sterilizations, and Abortions*. The criteria for utilization are communicated in the *Member Handbook*, the *Provider Manual*, and on the website. The applicable forms are correctly noted under the provider tab of the website.
4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					*Policy CC.UM.02, Clinical Decision Criteria and Application* describes how individual circumstances and clinical information pertaining to cases are reviewed and compared to the criteria.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					Policies *CC.UM.02, Clinical Decision Criteria and Application* and *CC.UM.02.05, Interrater Reliability* indicate annual inter-rater reliability (IRR) testing is conducted for clinical staff reviewers, physicians, non-physicians, and BH clinicians to evaluate consistency in application of UM criteria with an established benchmark of 90%. ATC provided policy *EPS.PHARM.10, Inter-rater reliability* during the onsite visit; the policy describes how the Pharmacy Authorization Department conducts IRR testing for pharmacy reviewers quarterly with a benchmark of 100%.
6. Pharmacy Requirements						
6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	X					Formulary restrictions are noted on the *Preferred Drug List (PDL)*, which identifies over-the-counter (OTC) medications that are covered and negative PDL changes are posted on the website at least 30 days prior to implementation. The Pharmacy and Therapeutics (P&T) Committee consists of community-based practitioners and pharmacists who make decisions regarding PDL management activities. During the Onsite visit, CCME discussed the following observations: •drug changes in the *PDL Updates* do not consistently state what the previous drug requirements were and what the current changes are (i.e. quantity limit changed from 2.0ml per 30 days to 2.5ml per 30 days) •Q3 P&T Committee meeting minutes (page 7) do not capture all of the drugs in the Q3 *PDL Updates* identified as REMOVE •Q4 P&T Committee Minutes (page 8) says, “There are no PDL changes for this quarter;” however, Q4

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						2018 *PDL Updates* has 3 drugs noted as "CHANGE," and the PA is removed. *Recommendation: When communicating drug changes in the PDL Updates, indicate what the previous requirement was and what the current requirement is. Ensure respective P&T Committee minutes and PDL Updates have consistent documentation.*
6.2 If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity.	X					*Policy, SC.PHAR.01, 72-Hour Emergency Supply Of Medication* indicates a 72-hour supply of medication will be approved while a prior authorization request is pending, and *Policy SC.PHAR.07, Specialty Pharmacy Program* describes pharmacy requirements for specialty medications.
7. Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations.	X					
8. Utilization management standards/criteria are available to providers.	X					
9. Utilization management decisions are made by appropriately trained reviewers.	X					The *UM Program Description* and policies such as *CC.UM.04, Appropriate UM Professionals* and *CC.UM.02, Clinical Decision Criteria and Application*, describe staff who are licensed and trained to perform physical and BH clinical reviews. Policy *CC.PHAR.08, Pharmacy Prior Authorization and Medical Necessity Criteria* indicates Certified Pharmacy Technicians or Clinical Pharmacists at Envolve Pharmacy Solutions conduct initial UM reviews. The appropriate Medical Director or Clinical Pharmacist render denials and review cases the UM staff cannot approve.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
10. Initial utilization decisions are made promptly after all necessary information is received.	X					Service authorization time frames for approval files are consistent with Policy *SC.UM.05, Timeliness of UM Decisions* and *Notifications*, the *UM Program Description*, and *SCDHHS Contract* requirements.
11. Denials						
11.1 A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent information prior to making the decision to deny services.	X					
11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					Review of 15 files with adverse benefit determinations reflect decisions are made by the appropriate physician specialist as outlined in *Policy CC.UM.04, Appropriate UM Professionals*.
11.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.	X					Denial files reveal denial decisions are made according to the processes described in *Policy SC.UM.05, Timeliness of UM Decisions and Notifications*.
V C. Appeals						
1. The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including:	X					*Policy SC.UM.13, Member Appeals* outlines the appeals processes. Additionally, instructions are provided in the *Provider Manual*, *Member Handbook*, and the member tab on the website. Onsite discussions revealed *Policy SC.UM.13, Member Appeals* applies to BH and pharmacy appeals.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Edit Policy SC.UM.13, Member Appeals to indicate it applies to BH and pharmacy appeals.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					The definitions of an adverse benefit determination and an appeal and who may file an appeal are described in *Policy SC.UM.13, Member Appeals*, the *Provider Manual*, the *Member Handbook* and the website. During the onsite, CCME discussed *Policy, CC.PHAR.08, Pharmacy Prior Authorization and Medical Necessity Criteria* which references the terms "adverse determination" (page 2) and "adverse coverage determination" (page 3). *Recommendation: Edit Policy CC.PHAR.08, Pharmacy Prior Authorization and Medical Necessity Criteria to use current SCDHHS Contract terminology of "adverse benefit determination" instead of "adverse coverage determination" and "adverse determination."*
1.2 The procedure for filing an appeal;	X					CCME identified inconsistent calendar days defining when receipt of written confirmation is required. *Policy SC.UM.13, Member Appeals*, the *Provider Manual*, the *Member Handbook*, and the member website, indicate ATC has14 calendar days to receive a written request confirming an oral appeal. However, the provider website incorrectly references 30 calendar days for receiving written confirmation requests of an oral appeal. During the onsite visit ATC confirmed receipt of written confirmation is required within 14 calendar days.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Additionally, the timeframe from when the calendar days begin, for receiving written confirmation requests, is not clearly described in the *Provider Manual*, *Member Handbook*, and the member and provider website sections. ATC confirmed the timeframe is within 14 calendar days from when the standard oral appeal is filed, or for an appeal request that is not filed by the member. *Recommendation: To be consistent with Policy SC.UM.13, Member Appeals, the Provider Manual, the Member Handbook, and the member website, edit the provider website to references 14 calendar days for receiving written confirmation requests for oral appeals. Additionally, clearly indicate the timeframe from when the calendar days begin, for receiving written confirmation requests, in the Provider Manual, Member Handbook, and the member and provider website sections.*
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					*Policy SC.UM.13, Member Appeals Policy*, the *Member Handbook, and* the *Provider Manual* indicate standard appeals are resolved within 30 calendar days of receipt and expedited appeals are resolved within 72 hours of receipt.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						During the onsite visit, ATC confirmed the appeal resolution timeline begins with receipt of the member's consent. However, *Policy SC.UM.13, Member Appeals* notes the following different start times for when the appeal timeline begins: •Page 4 states "The timeline for the appeal begins with Absolute Total Care's receipt of the member's initial notification of appeal (oral or written)." •Pages 2, 4, and 6 state, "The appeal timeline will begin when the signed member's consent is received." *Recommendation: Edit Policy SC.UM.13, Member Appeals to clarify when the appeal resolution timeline begins and clearly indicate circumstances when appeal start times may differ. Ensure requirements in SCDHHS Contract, Section 9.1.4.4.1. are met.*
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					
2. The MCO applies the appeal policies and procedures as formulated.	X					Review of appeal files reflect determinations are appropriately acknowledged and resolved timely.
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					*Policy SC.UM.13, Member Appeals* and *Policy SC.QI.06, Member Experience Analysis* states appeals are reported to the Quality Improvement Committee at least annually. Medical and BH appeals are separately tallied, categorized, and analyzed for trends and potential improvement opportunities as

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						identified in the *2017 ATC Medicaid QI Evaluation*. Categories for medical necessity appeals include pharmacy, outpatient, inpatient, and durable medical equipment.
4. Appeals are managed in accordance with the MCO confidentiality policies and procedures.	X					
V. D Care Management and Coordination						
1. The MCO formulates policies and procedures that describe its case management/care coordination programs.	X					The *2018 Care Management Program Description* and *Policy SC.CM.02, Care Coordination/Care Management Services* outline the framework for case management/care coordination program goals, objectives, lines of responsibility, and operations for physical and behavioral health services. *Policy CC.CM.11, Disease Management Programs* indicates components of care management (CM) functions are included in ATC's disease management programs. Additionally, the *Provider Manual* and *Member Handbook* provide descriptions of the CM program.
2. The MCO has processes to identify members who may benefit from case management.	X					The *Care Management Program Description* and *Policy SC.CM.02, Care Coordination/Care Management Services* and other policies describe methods of how eligible members are identified and referred into case management such as: review of clinical claims, health risk assessment results, medical records, and utilization management data. Identified members are stratified into low, moderate, or high categories based on results from ImpactPro predictive modeling software.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The MCO provides care management activities based on the member's risk stratification.	X					The *Medicaid Care Management Program Description* and *Policy SC.CM.02, Care Coordination/Care Management Services* describe ATC's approach to member engagement based on the member's risk level of low, moderate or critical/high. Levels of CM services, from least intensive to most intensive, include care coordination, care management, and complex care management.
4. The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members.	X					During the onsite visit, CCME discussed how the *CM Program Description* (page 18) does not include Targeted Case Management referrals for alcohol and substance abuse individuals, children in foster care, and children in the juvenile justice system. *Recommendation: Edit the CM Program Description to include Targeted Case Management referrals for alcohol and substance abuse individuals, children in foster care and children in the juvenile justice system as required in the SCDHHS Contract, Section 4.2.27 and the SCDHHS Policy and Procedure Guide for Managed Care Organizations under Targeted Case Management Services (page 42).*
5. Care Transitions activities include all contractually required components.						
5.1 The MCO has developed and implemented policies and procedures that address transition of care.	X					Together, policies *SC.UM.41.01, Transition of Care* and *CC.UM.20, Continuity and Coordination of Services Care Transitions* include required components that address transition of care. However, CCME did not identify the requirement in *SCDHHS Contract, Section 5.6.6.5 regarding Members in the appeal process* in either policy.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Edit Policy SC.UM.41.01, Transition of Care or Policy CC.UM.20, Continuity and Coordination of Services Care Transitions to include SCDHHS Contract, Section 5.6.6.5 Members with appeals in process. Additionally, cross reference the policies to assist staff in locating complete transition of care requirements.
5.2 The MCO has a designated Transition Coordinator who meets contract requirements.			X			CCME could not identify a Transition Coordinator during review of desk materials, and ATC did not identify a designated Transition Coordinator during onsite discussions. *Quality improvement Plan: Designate a person with appropriate training and experience as Transition Coordinator, as required in SCDHHS Contract, Section 5.6.2.*
6. The MCO measures case management performance and member satisfaction and has processes to improve performance when necessary.	X					*Policy SC.CM.08, Care Management Member Satisfaction Survey* and the *2017 CM Member Satisfaction Report* describe the purpose and process used to measure member satisfaction. T*he 2018 Medicaid Care Management Program Description* indicates all aspects of the program are measured and analyzed annually and the information obtained is used to assess strengths and weaknesses. Evaluation results and recommendations are submitted to the QIC and reflected in the April 2018 QIC minutes.
7. Care management and coordination activities are conducted as required.	X					Sampled files indicate CM activities are conducted as required and Care Managers follow policies to conduct the appropriate level of case management. HIPAA verification and identifying care-gaps are addressed consistently.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V E. Evaluation of Over/ Underutilization						
1. The MCO has mechanisms to detect and document under-utilization and over-utilization of medical services as required by the contract.	X					
2. The MCO monitors and analyzes utilization data for under and over utilization.	X					ATC analyzed and monitored data for several services regarding utilization and offered recommendations based on findings in the committee meetings and in the program evaluations.

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I. DELEGATION						
1. The MCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the	X					*Policy CC.COMP.21, Third Party Oversight Program Description*, describes the Centene Third Party Oversight Program (TPOP) for national vendors. The TPOP has several components to promote

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
contractor or agency in performing those delegated functions.						communication, collaboration, and ensure third party adherence to state, federal, and NCQA requirements, as applicable. The oversight and monitoring of third parties involve coordinated activities between Corporate Compliance Performance Office, National Contracting, Procurement, business owners, Corporate, the Entities, and third parties. ATC ensures written agreements with all third parties performing delegated functions. ATC delegates the following services: •Envolve PeopleCare Behavioral Health: Utilization Management (UM) •National Imaging Associates (NIA): UM, Credentialing/Recredentialing, Network Development & Maintenance. •Envolve PeopleCare (Legacy Nutur & NurseWise): Disease Management •Envolve PeopleCare: Nurse Advice Line •Envolve Vision: Claims Adjudication, Credentialing/ Recredentialing, Network Development & Maintenance. •Envolve Pharmacy Solutions: Pharmacy Benefit Management - UM, Claims Adjudication, Network Development & Maintenance. •Credentialing Delegations: CVS Minute Clinic, AU Medical Center/Medical College of Georgia (MCG/PPG), Greenville Health Systems, Health Network Solutions (HNS), Management Network Services, Mary Black Network, MUSC – Medical University of South Carolina, Preferred Care of Aiken, St. Francis Physician Services, Inc., Palmetto USC/ University of South Carolina Medical Group, AnMed Health, and Roper St Francis Envolve PeopleCare is a wholly-owned subsidiary of Centene Corporation, and ATC staff reported that

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						even though oversight will be conducted, they may not be considered delegated functions in the future. Onsite discussion confirmed some of the behavioral health related services conducted by Envolve PeopleCare transitioned back to the health plans in 2018.
2. The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions.		X				*Policy CC.CRED.12, Oversight of Delegation Credentialing* addresses credentialing delegation and *Attachment J* of the policy addresses ATC's unique delegated credentialing requirements. *Attachment J* does not include the Suspended List and the Behavioral Health Actions List as queries required by SCDHHS Program Integrity. *Policy CC.CRED.12* states if the delegate is NCQA Certified or Accredited, the plan may omit the annual audit; however, the *SCDHHS Contract, Section 2.5.8* includes the requirement to monitor the subcontractor's performance on an ongoing basis, to include annual review. CCME recommends adding a statement to *Attachment J* that annual audits are required regardless of the delegated entity's accreditation status. *Exhibit B, Health Plan Unique Requirements Grid 2017/2018* does not include the Suspended List and the Behavioral Health Actions List as required queries. In addition, *Exhibit B* health plan specific elements do not match the health plan specific elements listed in the tool used for delegation oversight. ATC needs to update *Exhibit B* to reflect the current oversight tool.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						CCME received evidence of annual oversight review for all delegated entities. A few concerns are noted for the credentialing delegation oversight: •In some cases, the annual oversight letter indicates a score of 100%, yet corrective action items are documented. ATC indicated this is misleading during onsite discussion, and as a result they had changed their scoring tool. •There does not appear to be a clear process for following up on deficiencies found in the annual oversight audit. This is evidenced by letters that do not mention whether a CAP is required or a date by which the CAP items need to be addressed. The letter simply gives the score (i.e. 82%), and then indicates the items will be reviewed for compliance during the next annual audit. •Some SCDHHS Program Integrity required queries were not evaluated in the file review. *Quality Improvement Plan:* Add a statement to *Policy CC.CRED.12, Attachment J* that annual audits are required regardless of the delegated entity's accreditation status. Update *Attachment J* and *Exhibit B* for *Policy CC.CRED.12* to reflect all queries required by SCDHHS Program Integrity and ensure the queries are addressed in the file review oversight. Ensure *Policy CC.CRED.12 Exhibit B* health plan specific elements match the current oversight tool. Implement a corrective action plan follow-up process to ensure deficiencies identified in the delegated entity oversight audits are corrected by a specified date. *Recommendation: Ensure delegation oversight letters do not reflect a score of 100% when deficiencies have been identified in the review.*

VII. STATE-MANDATED SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I I. STATE-MANDATED SERVICES						
1. The MCO tracks provider compliance with:						
1. The MCO tracks provider compliance with:						
1.1 administering required immunizations;	X					As a required component of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements, ATC ensures pediatric and adolescent immunization requirements are monitored by reviewing immunization rates for each provider as described in the *Provider Manual*. The 2017 Medicaid Quality Assessment and Performance Improvement Program Evaluation reports HEDIS immunization rates and lists improvement opportunities.
1.2 performing EPSDTs/Well Care.	X					ATC follows the EPSDT periodicity schedule for members through 21 years of age. Provider compliance with providing EPSDT services is monitored through HEDIS medical record reviews and HEDIS reports of Well-Child Visits. Additionally, EPSDT services is one of the Preventive Health Reminder Programs where providers receive targeted telephonic or in-person education and notification of members' missed or upcoming services.
2. Core benefits provided by the MCO include all those specified by the contract.	X					Onsite discussion revealed the Core benefit for newborn hearing screenings rendered to newborns in an inpatient hospital setting is part of EPSDT services.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The MCO addresses deficiencies identified in previous independent external quality reviews.	X					